[] EAST LOS ANGELES CAMPUS 443 SOTO STREET LOS ANGELES, CA 90033 [] SUBURBAN MEDICAL CENTER CAMPUS 16453 S. COLORADO AVE. PARAMOUNT, CA 90723

PATIENT NAME:	ACCT.#:					
DOS FROM:	FROM: DOS TO:		TOTAL CHARGES:			
	GUARANTOR/RE	SPONSIBLE	PARTY			
NAME:			SSN:			
ADDRESS 1:			[] SINGLE	[] MARRIED		
ADDRESS 2:			[] DIVORCED	[] WIDOWED		
CITY:		STATE: _	ZI	P:		
HOME PHONE #:	CELL #:		EMAIL:			
EMPLOYER NAME:		EMPLO	YER PHONE #:			
EMPLOYER ADDRESS:						
EMPLOYER CITY, STATE & ZIP: _						
POSITION/TITLE:		НС	OW LONG:			
MONTHLY GROSS INCOME:		MONTHLY NET INCOME:				
	SDOILSE II	NEODMATION	.i			
NAME:		NFORMATION				
ADDRESS 1:						
ADDRESS 2:			[] DIVORCED			
CITY:						
		EMAIL:				
EMPLOYER NAME:		EMPLOYER PHONE #:				
EMPLOYER ADDRESS:						
EMPLOYER CITY, STATE & ZIP: _						
POSITION/TITLE:		НС	DW LONG:			
MONTHLY GROSS INCOME:		MONTHLY	/ NET INCOME:			
	DEPE	NDENTS				
NAME:	DOB:		RELATIONSHIP:			
NAME:						
NAME:						

NAME:	DOB: RELATIONSH			HIP:
NAME: DC		DOB:	RELATIONSH	HIP:
NAME: DO		DOB:	RELATIONSH	HP:
		DOB:	RELATIONSH	HIP:
TOTAL DEPENDENTS IN	HOUSEHOLD:			
DOES ANYONE ELSE LIV	VE IN THE HOUSEHOLD?	[] YES [] NO) IF YES, PLEASE IDE	NTIFY:
NAME:		DOB:	RELATIONSH	HP:
NAME:		DOB:	RELATIONSH	HIP:
DO THESE PEOPLE CON	ITRIBUTE TO HOUSEHOLD	INCOME? [] YE	S [] NO IF YES, HOV	W MUCH PER MONTH: \$
	MC	ONTHLY INCOME	& ASSETS	
GROSS WAGES/SALARY	f: \$	Ch	HILD SUPPORT/ALIMON	Y \$
SOCIAL SECURITY INCO	DME: \$	RE	ENTAL INCOME:	\$
WORKERS COMP:	\$	GF	RANTS:	\$
UNEMPLOYMENT:	\$	IR.	A/401K:	\$
PUBLIC ASSISTANCE:	SSISTANCE: \$ SAVINGS:		\$	
FOOD STAMPS: \$ OTHE		HER:	\$	
WHAT IS THE SOURCE (OF OTHER INCOME?			
TOTAL GROSS INCOME:	>>>>>>>>>>>>	>>>>>>>	>>>>>>>>>>>	>\$
COMMENT:				
		MONTHLY EXP	ENSES	
MORTGAGE:	\$	AL	JTO PMTS	\$
RENT:	\$	AL	JTO EXPENSES (FUEL)	\$
ELECTRIC:	\$	AL	JTO INSURANCE	\$
GAS:	\$	_ HE	EALTH INSURANCE	\$

LIFE INSURANCE

MEDICAL/DENTAL

CHILD SUPPORT

\$

WATER/SEWER:

TRASH:

CABLE:	\$	CREDIT CARD 1:	\$				
MEDICAL/DENTAL	\$	CREDIT CARD 2:	\$				
CREDIT CARD 1:	\$	OTHER CREDIT CARD:	\$				
CREDIT CARD 2:	\$	INSTALLMENT LOANS:	\$				
OTHER CREDIT CARD:	\$	MISCELLANEOUS:	\$				
OTHER, EXPLAIN:	\$						
TOTAL ELIGIBLE MONTH	LY EXPENSES >>>>>>>>>>>>>>	>>>>>>>>>>>	> \$				
I CERTIFY THAT THE INFORMATION I HAVE PROVIDED ABOVE IS TRUE AND ACCURATE. I AUTHORIZE A CREDIT BUREAU REPORT TO BE SECURED BY THE HOSPITAL OR ITS AGENT TO VERIFY MY FINANCIAL POSITION, IF NECESSARY.							
APPLICANT SIGNATURE DATE							
APPLICANT SIGNATURE DATE							
HOSPITAL REPRESENTA	TIVE	_	DATE				

	FOR HOSPITAL OFFICE USE O	NLY	
QUALIFIED GROSS INCOME	\$		
QUALIFIED EXPENSES	\$		
TOTAL NET INCOME	\$		
QUALIFIED NUMBER OF DEPENDENTS	S		
FPL THRESHOLD	\$		
QUALIFIED INCOME AS % OF FPL	%		
DOES APPLICANT QUALIFY FOR:	[] FULL CHARITY CARE?	[] YES	[] NO
	DISCOUNT PARTIAL CHARITY CARE?	[] YES	[] NO
	OTHER (SPECIFY)?	[] YES	[] NO
ELIGIBLE PATIENT ACCOUNT ADJUST	MENTS:		

ACCOUNT #	ADJUSTMENT CODE	ADJ. AMOUNT	
PROGRAM DIRECTOR		DATE	
CFO		DATE	

PROMISE HOSPITAL OF EAST LOS ANGELES, L.P.

FINANCIAL ASSISTANCE PROGRAM - FEDERAL POVERTY GUIDELINES 2008

PERSONS IN HOUSEHOLD	THRESHOLD	125%	150%	200%	300%	350%	400%	450%	500%
1	10,400	13,000	15,600	20,800	31,200	36,400	41,600	46,800	52,000
2	14,000	17,500	21,000	28,000	42,000	49,000	56,000	63,000	70,000
3	17,600	22,000	26,400	35,200	52,800	61,600	70,400	79,200	88,000
4	21,200	26,500	31,800	42,400	63,600	74,200	84,800	95,400	106,000
5	24,800	31,000	37,200	49,600	74,400	86,800	99,200	111,600	124,000
6	28,400	35,500	42,600	56,800	85,200	99,400	113,600	127,800	142,000
7	32,000	40,000	48,000	64,000	96,000	112,000	128,000	144,000	160,000
8	35,600	44,500	53,400	71,200	106,800	124,600	142,400	160,200	178,000
9	39,200	49,000	58,800	78,400	117,600	137,200	156,800	176,400	196,000
10	42,800	53,500	64,200	85,600	128,400	149,800	171,200	192,600	214,000

For each additional person, add \$3,600.00