

# Charity Guidelines

## CHARITY CARE AND LOW INCOME FINANCIAL ASSISTANCE APPLICATION AND GUIDELINES

Poverty Guideline	Family Size	100%	250%	350%
10,830	1	10,830	\$27,075	\$37,905
14,570	2	14,570	36,425	\$50,995
18,310	3	18,310	45,775	\$64,085
22,050	4	22,050	55,125	\$77,175
25,790	5	25,790	64,475	\$90,265
29,530	6	29,530	73,825	\$103,355
33,270	7	33,270	83,175	\$116,445
37,010	8	37,010	92,525	\$129,535
40,490	9	40,490	101,225	\$141,715
43,970	10	43,970	109,925	\$153,895
47,450	11	47,450	118,625	\$166,075
50,930	12	50,930	127,325	\$178,255
54,410	13	54,410	136,025	\$190,435
57,890	14	57,890	144,725	\$202,615
61,370	15	61,370	153,425	\$214,795
64,850	16	64,850	162,125	\$226,975
68,330	17	68,330	170,825	\$239,155
71,810	18	71,810	179,525	\$251,335
75,290	19	75,290	188,225	\$263,515
78,770	20	78,770	196,925	\$275,695
<b>Add for each additional member</b>		3,480	8,700	

**Number of family members:**

<----- Enter number of family members

**Annual Income**

<----- Enter total gross annual income

## Statement

I certify that the information provided is true and accurate to the best of my knowledge. Further, I have or will apply for any assistance (MediCal, Medicare, insurance, etc.) which may be available for payment of medical services, and that I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for medical services.

I understand that this application is made for the hospital to evaluate eligibility for charity services. I also understand that the hospital will verify the information which may include obtaining a credit report. If the information I have given proves to be untrue, or if I fail to comply with the referral process for MediCal, Medicare, California Children's Services, or other identified programs this will result in forfeiture of the right to be considered for Charity Care.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

## Unemployed Attestation Form

I hereby acknowledge that I am currently unemployed and all information provided herein is true and correct to the best of my knowledge. If I am receiving unemployment compensation, I will attach a copy of my unemployment checkstub. I understand that providing false information will result in denial of this Application. Additionally depending upon local and states statutes, providing false information to defraud a hospital for obtaining goods or services may be considered an unlawful act. I also acknowledge and consent that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Los Angeles Community Hospital Charity Care program is a "Payer of Last Resort" and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for fitness or injury, for which Los Angeles Community Hospital provided care.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

## Homeless Affidavit

I hereby acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in denial of this Application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services may be considered an unlawful act. I also acknowledge and consent that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Los Angeles Community Hospital Charity Care program is a "Payer of Last Resort" and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for fitness or injury, for which Los Angeles Community Hospital provided care.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_

*Los Angeles Community Hospital reserves the right to bill third party if appropriate.*

**Hollywood Community Hospital**

## Application Instructions

The following information and supporting documents must be provided to evaluate this application for a possible reduction of hospital expenses provided by Los Angeles Community Hospital.

**Please complete all sections of the application and provide one or more of the applicable documents. Return the application to the admitting department or return to the Business Office at the address listed below:**

**Hollywood Community Hospital  
FILE 51120  
Los Angeles, Ca. 90074-1120**

If you should need to contact the hospital regarding your application please call (562) 804-5830.

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List of documents required to complete Charity Application:

### **Proof of Gross Income**

- \*Check Stubs
  - \*Employers statement of earnings
  - \*W-2 form
  - \*Income Tax returns
  - \*Profit/loss statement from accountant (if self employed)
  - \*Homeless Affidavit
  - \*Unemployed Attestation
  - \*Social Security / Disability
  - \*Workers Compensation
  - \*Strike Benefits
  - \*Welfare/AFDC/General Relief
  - \*Veteran's Benefits
  - \*Stipends
  - \*Alimony
  - \*Child Support
  - \*Military Family Allotments
  - \*Private or Government Pensions
  - \*Proceeds from Insurance or Annuity Payments
  - \*Income from Dividends
  - \*Interest Income
  - \*Rents
  - \*Royalties
  - \*Farm Income (after expenses)
  - \*Support from Family Members or someone not living in the household
- \*Assets  
\*Bank Statement

***If no proof of income, please submit a copy of recent tax return.***

***Hollywood Community Hospital***

## Personal Information

Patient Name:				
Patients place of birth:			Account Number:	
Guarantor Name:				
Address:				
Does the patient have medical insurance?		Yes	No	Name:
Is patient a California Resident?		Yes	No	
County of Residence:				
Total family members:				

Name	Age	Date of Birth	Social Security Number	Relationship to Patient

*Assets/Income/Resources*

Employee/Employer Name	Employer Information	Monthly Income (prior to taxes)
Employee Name:  Telephone Number:	Address:	\$ -
Employee Name:  Telephone Number:	Address:	\$ -
Employee Name:  Telephone Number:	Address:	\$ -
Employee Name:  Telephone Number:	Address:	\$ -
		\$ -

Funds	Investments
Checking:	Money Market Funds:
Savings:	Stocks:
	Bonds:

