PIONEERS MEMORIAL HOSPITAL DISTRICT
207 WEST LEGION ROAD
BRAWLEY, CA 92227

FULL CHARITY CARE, DISCOUNTED CHARITY CARE AND HIGH MEDICAL CHARITY CARE STATEMENT OF FINANCIAL CONDITION

APPLICANT'S NAME:________________________________ **SPOUSE NAME:** ____________________________________

ADDRESS:____ **PHONE:**____

ACCOUNT #:______________________________________ **SSN:** ____________________ ____________________
(APPLICANT) **(SPOUSE)**

FAMILY STATUS (List all dependents that you support)

NAME	RELATIONSHIP	AGE	SEX
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female

FAMILY SIZE

Total Family Members (add applicant, spouse and dependents from above):___________

EMPLOYMENT AND OCCUPATION

APPLICANT'S EMPLOYER:____ POSITION:____________________________

CONTACT PERSON & TELEPHONE: ____________________________________

IF SELF EMPLOYED, NAME OF BUSINESS:____

SPOUSE'S EMPLOYER:____ POSITION:____________________________

CONTACT PERSON & TELEPHONE: ____________________________________

IF SELF EMPLOYED, NAME OF BUSINESS:____

CURRENT INCOME (Select One): Weekly____ Bi-Weekly____ Monthly ____ Yearly____ Other____

CATEGORY	APPLICANT	SPOUSE	OTHER FAMILY MEMBER
Gross Pay (before deductions):	$	$	$
Farm or self employment:	$	$	$
Public Assistance:	$	$	$
Social Security:	$	$	$
Unemployment Compensation:	$	$	$
Workman's Compensation:	$	$	$
Strike Benefits:	$	$	$
Alimony:	$	$	$
Child Support:	$	$	$
Military Family Allotments:	$	$	$
Pensions:	$	$	$
Income from Dividends and Interest:	$	$	$
Income from Rent, Real Estate or Property:	$	$	$
TOTAL:	**$**	**$**	**$**

COMPLETE SECTION _____ (PMHD Representative to place X in appropriate box)

☐ **A. FULL CHARITY CARE AND DISCOUNTED CHARITY CARE – MONETARY ASSETS (must include assets for applicant, spouse and other family member listed on page 1 of 3)**

ASSETS

Cash on Hand:	$______________
Checking Account Balance:	$______________
Savings Account Balance	$______________
Credit Union Account Balance:	$______________
Trust Accounts:	$______________
Additional Income:	$______________
TOTAL MONETARY ASSETS:	**$_____________**

In order for us to consider your request, you must include one of the following items:

1. Verification of income. (Note: Normally income consideration will be based on, but not limited to, the average of the previous three (3) months. Sometimes, however, in certain cases, e.g. self-employment, it may be appropriate to use an averaging of the previous 12 months' income. PMHD reserves the right to determine the most fair and appropriate application of this policy.)

2. Last years' tax returns

☐ **B. HIGH MEDICAL CHARITY CARE (LIABILITY AFTER INSURANCE {EXCLUDES HMO AND PPO}) – MONETARY ASSETS AND LIABILITIES (must include monetary assets and liabilities for applicant, spouse and other family member listed on page 1 of 3)**

ASSETS		MONTHLY LIABILITIES	
Cash on Hand:	$______________	Real-Estate Payments:	$______________
Checking Account Balance:	$______________	Rental Payment (Home or Apartment):	$______________
Savings Account Balance	$______________	Ins. Premiums (Auto, Home, Medical):	$______________
Credit Union Account Balance:	$______________	Avg. Annual Taxes:	$______________
Property Owned Value:	$______________	Avg. Monthly Utilities:	$______________
Home Value (if owned):	$______________	Other Liabilities (provide descriptions):	
Trust Accounts:	$______________	_______________________________	$______________
Additional Income:	$______________	_______________________________	$______________
Automobile(s) Estimated Value:	$______________	_______________________________	$______________
Make & Model: ___________________________		_______________________________	$______________
Make & Model: ___________________________		_______________________________	$______________
Make & Model: ___________________________		_______________________________	$______________
TOTAL MONETARY ASSETS:	**$_____________**	**TOTAL LIABILITIES:**	**$______________**

MEDICAL EXPENSES INCURRED AND PAID

Total patient's out-of-pocket costs incurred at this hospital in prior 12 months (net of any discounts or write-offs): $________________

Total patient and patient's family out-of-pocket medical expenses (including but not limited to, hospital services, physician services, drugs, and all other medical services) paid by the patient or patient's family in prior 12 months: $________________

In order for us to consider your request, you must include the following items:

1. Verification of income. (Note: Normally income consideration will be based on, but not limited to, the average of the previous three (3) months. Sometimes, however, in certain cases, e.g. self-employment, it may be appropriate to use an averaging of the previous 12 months' income. PMHD reserves the right to determine the most fair and appropriate application of this policy.)

2. Last years' tax returns

3. Checking and/or savings accounts statements for the past two months

4. Copies of rental or mortgage payment (1 month)

5. Copies of utilities bills (1 month)

6. Copy of auto loan payments (1 month)

7. Copies of other outstanding liabilities

By signing this completed Statement of Financial Condition form, I hereby declare the foregoing to be true under penalty of perjury under the laws of the state of California. I also agree to allow PMHD to check employment and credit history for the purpose of determining my eligibility for a financial discount.

____ ____________________
(Applicant's signature) (Date)

____ ____________________
(Spouse's signature) (Date)