# Appendix A: Charity Care Application Form

**1. Applicant Information.**

Last Name_____ First _____ MI _____

Street Address

_____

City _____State_____Zip Code_____

Home phone_____Work_____Cell_____

Mailing Address if different from Street Address_____

Date of Birth _____ Male _____ Female_____ Are you pregnant? Yes ____ No ____

**Are you homeless? Yes _____ No _____ Are you uninsured? Yes _____ No _____**

**Are you unemployed? Yes _____ No _____**

**2. If you are applying for someone else, complete this section.**

Last Name_____ First_____ MI _____

Street Address

_____

City _____State_____Zip Code_____

Home phone_____Work_____Cell_____

Relationship to Applicant _____

**3. Family Information.** List the people in your family that live with you and you support with your income. Include your spouse, dependent children under age 18, and dependent elders that live with you. If this application is for a child under age 18, include brothers or sisters under 18 and the child's parent or parents who live with you.

| Name of family member | Relationship | DOB | Gender | Pregnant |
|---|---|---|---|---|
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| | | | | |
| | | | | |
| | | | | |

**4. List Earned Income** before taxes and deductions for each family member who works.

| Name, working members | Employer and Address | Amount Earned | How Often |
|---|---|---|---|
| | | | |
| | | | |

**5. Other Income not from an employer.**

| Name, family member | Type of income (pick from list | Amount | How Often |
|---|---|---|---|

| | | | |
|---|---|---|---|
| receiving | below) | | |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| Social Security | Bank Account Income | Pensions | Rental Income |
| Railroad Retirement | Annuities | Child Support | Trust Income |
| Veterans' Benefits | Workers Comp | Alimony | County General Relief |
| Retirement Funds | Dividend income | Unemployment | Refugee Resettlement Program |

**6. Other Expenses.** Fill in this section if you or anyone in Section 3 is required to make payments for alimony, child support, or personal needs allowance for a family member in a nursing home.

| Expense Payment Type | Recipient Name | How much | How often |
|---|---|---|---|
| | | | |
| | | | |

**7. Other Insurance.** Charity Care can pay for such things as your co-payments and deductibles even if you have other health insurance.

a. Are you covered under any health insurance program, including Medicare? Y ___ N ____

b. If yes list policy holder name, insurance company and policy number:

_____
_____

c. Are you seeking Charity Care because of a work-related accident or injury? Y ___ N ____

c. Are you seeking Charity Care because of a car accident? Y _____ N _____

d. Are you a student? Y ___ N ___ If yes, are you full time? _____ part time? _____

e. Do you have an application pending for any of these programs? *(Check all that apply)*

Medicaid _____ Medicare _____

f. Are you currently approved for Charity Care at another hospital or community health center?

Y ___ N ____ If yes, where?_____

**8. Medical Bills.** Total medical bills _____

Why can't you pay your medical expenses? Why do you need Charity Care?

_____
_____
_____
_____

**9. Ethnicity/Race.** Ethnicity/Race will not be used to determine eligibility.

- ❑ Asian or Pacific Islander
- ❑ African-American, not Latino
- ❑ Latino
- ❑ American Indian or Alaskan Native
- ❑ Caucasian, not Latino
- ❑ Other_____
- ❑ I do not wish to answer.

This is for data collection and analysis purposes only.

**10. Assignment of Rights.** Read this section carefully and sign.
I agree to tell this hospital about changes to my family status including family size, income, and insurance coverage that could change my eligibility for Charity Care. All information in this application is true to the best of my knowledge. I agree to provide documentation upon request.

_____ _ _____
Signature of applicant Date

_____ __ _____
Signature of authorized representative Date

If you have questions about this application, contact the Charity Care Representative at 661-864-4002 Mail the completed application to:

HealthSouth Bakersfield Rehabilitation Hospital
Controller
5001 Commerce Drive
Bakersfield, CA 93309