Exhibit B Charity Evaluation Form

Patient Name: TEST, JANE Patient Visit Number: **[FIN #]**

CHARITY CARE EVALUATION FORM

Schedule of Current Income and Expenditures

TEST, JANE TEST, JANE

15966 ANYSTREET
SOMEWHERE, CA 11111

[Patient Phone #]
Phone

Social Security Number: **[SS#]** _____
(Patient) (Spouse)

EMPLOYMENT AND OCCUPATION

[Employer Name]
Employer

[Position Title]
Position

_____ _____
Contact Person

_____
If self-employed, give name of business

_____
Spouse's Employer

_____
Position

_____
Contact Person

_____
If self-employed, give name of business

COLLEGE MEDICAL CENTER

SUBJECT: **Charity Care and Discount Payment Policy** POLICY #: AD-00-125

Patient Name: TEST. JAME Patient Visit Number: **[FIN #]**

CURRENT MONTHLY INCOME

	Patient	Spouse
Gross pay from employment: (Before deductions)	$_____	$_____
Income from operating business: (If self-employed)	$_____	$_____
Tax Return:	$_____	$_____
Total current monthly income: (Add all figures from above)	$_____	$_____

ASSETS AND DEBTS

Please provide your best estimate of the value of any homes, cars or similar assets. Also, indicate how much debt you currently have.

Assets:

a. Home and Property: $_____

b. Automobiles: $_____

c. Retirement plan: $_____

Investments/other (specify): $_____

Debts:

a. Amount owed on mortgages: $_____

b. Amount owed on automobiles: $_____

c. Amount owed on credit cards: $_____

d. Other: $_____

COLLEGE MEDICAL CENTER

SUBJECT: **Charity Care and Discount Payment Policy** POLICY #: AD-00-125

Patient Name: TEST, JANE

FAMILY STATUS

List all dependents you support

Name	Age	Relationship

I certify that the above stated information is true and correct. I authorize College Hospital to contact the employer's institutions on this application or a credit reporting agency to verify its accuracy. I further authorize the employers, institutions and/or credit reporting agencies to release such information to College Hospital.

(Date) (Signature of Patient or Guarantor)

(Date) (Signature of Spouse)