Encino Hospital Medical Center
5000 Van Nuys Blvd #325 ♦ Sherman Oaks, California 91403 ♦ (818) 501-0434

Application for Uncompensated Care/Charity/Indigent Care
To be Completed by Financial Responsible Party

Please complete this application in its entirety.

Account Number: _____

Date: _____

Name: _____

Patient Name: _____ Spouse Name: _____

Patient Employer: _____ Spouse Employer: _____

Patient Address: _____

City / State: _____

Phone Number: _____

Date of Birth: _____ Spouse Date of Birth: _____

Social Security Number_____ Spouse Social Security Number:_____

Guarantor Name: _____

Guarantor Employer_____

Guarantor Address: _____ Phone Number: _____

Guarantor Social Security Number_____

As provided for in Federal Law, I hereby request that ENCINO HOSPITAL MEDICAL CENTER make a determination of my eligibility for uncompensated services. I understand that the information that I submit concerning my annual income and family size is subject to verification by the hospital. I also understand that if the information is determined to be false, such determination will result in a denial of providing services as uncompensated services, and that I will be liable for charges for services provided.

Please fill out the following:	**Total for last 12 months**	
	Patient	**Spouse**
Wages:	$_____	$_____
Social Security	$_____	$_____
Strike Benefits	$_____	$_____
Alimony/Child Support	$_____	$_____
Military Allotment	$_____	$_____
Dividends/Interest	$_____	$_____
Pensions	$_____	$_____
Unemployment	$_____	$_____
Disability	$_____	$_____
IRA	$_____	$_____
Trust Account	$_____	$_____
Interest Income	$_____	$_____
Other	$_____	$_____

Proof of income attached: { } W-2 Form { } Pay check stubs { } Tax Return

Expenses:

House/Rent Payment $_____

Food:$_____

Water:$_____

Gas & Electricity:$_____

Trash:$_____

Child Support:$_____

Auto Expenses:$_____

Insurance:$_____

Credit Cards:

Company:_____ Balance Owing:$_____

Amount Available:$_____

Company_____ Balance Owing:$_____

Amount Available:$_____

Company_____ Balance Owing:$_____

Amount Available:$_____

Medical Bills:

Hospital/Doctor Names_____

Amount:$_____

Number of family members in household:_____

Name:_____ Relationship_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Bank References:

Checking: Name/Branch:_____ Account # _____

Savings: Name/Branch_____ Account # _____

Assets:

Do you own your own Home?_____ Value:_____

Do you own other property? _____ Value:_____

Do you own your own automobiles? _____ Value_____

I agree that my physician may be informed of the status of this application for uncompensated care.

I understand that I may be asked to prove my statements and that my eligibility statement will be subject to verification by contact with my employer, bank, credit verification and property searches.

I affirm that the statements made herein are true and correct to the best of my knowledge.

Signature of applicant: **_____ Date:_____**

Witness:_____ Date:_____

Revised 3/30/10