Gateways Hospital and Mental Health Center

CHARITY / DISCOUNT CARE ELIGIBILITY DETERMINATION

GENERAL					
Guarantor Name:					
Address:					
City:	State:	Zip:	Country:		
Phone ( )	How Long at this address?				
Method of Verification:	Power bill	Water bill	Drivers License		Other
Previous Address:					

Eligibility Requirements for Charity or Discout Care	
Social Security Number:	Date of Birth:
Place of Employment:	
Length of Employment: if not employed, what is your source of income?	
Gross income per month:	Number of dependents:
Spouse's Name:	
Spouse's Place of Employment: How long:	
Gross income per month:	Total Gross Income per month:
Verified by tax return: (year)	Do you have health insurance?
If so what type of insurance_____ and with whom?	
Effective Date:	Is a copy of card available?

MEDICAL ELIGIBILITY	
Have you applied for Medi-cal or any other government assistance Y or N If so when?	
Were you denied assistance? Y or N If denied why?	
Applicants Signature:	Date:
Applicants Signature:	Date: