Kindred Hospital South Bay

Application Form

Charity Care and Financial Assistance

Patient Name____

Address____

Telephone Numbers____

Name(s) of all members in household ______________________________________

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Employment of all members in household:

1. Name ________________________________
   Employer Name_________________________
   Monthly Income_________________________
2. Name________________________________
   Employer Name_________________________
   Monthly Income_________________________
3. Name________________________________
   Employer Name_________________________
   Monthly Income_________________________

Reason(s) for the request for Charity Care or Financial Assistance ______________

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To complete this application, the following documents must be attached: Prior Year 1040 Income Tax Return; Prior two months employment payroll check statements; outstanding balances of medical bills; proof of payment of out-of-pocket medical expenses within the last twelve (12) months. Documentation of ineligibility for government sponsored programs including Medi-Cal and Medicare.

The undersigned responsible party attests that all information provided in this application and attached documents is correct and valid. The undersigned responsible party authorizes Kindred Hospital South Bay to investigate the financial data presented in this application including employment records and status, credit history, and any other related data source that supports the financial information presented in this application.

Name of Responsible Party ____

Signature of Responsible Party ____

Date of Application____