CHINESE HOSPITAL
845 JACKSON STREET
SAN FRANCISCO, CA 94133
415-982-2400

APPLICATION FOR CHARITY CARE

NAME: LAST	FIRST	M.I.
ADDRESS: STREET	CITY/STATE	ZIP CODE

SOCIAL SECURITY NUMBER	HOME PHONE	EMPLOYER

	LAST 12 MONTHS	LAST 3 MONTHS x 4	FAMILY SIZE
PATIENT'S GROSS INCOME			
OTHER FAMILY INCOME			
TOTAL FAMILY INCOME			

TYPE OF SERVICE RENDERED/REQUESTED:

DATE(S) OF SERVICE:

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. FURTHER, I WILL MAKE APPLICATION FOR ANY ASSISTANCE (MEDI-CAL, MEDICARE, INSURANCE, ETC.) WHICH MAY BE AVAILABLE FOR PAYMENT OF MY HOSPITAL CHARGE, AND I WILL TAKE ANY ACTION REASONABLY NECESSARY TO OBTAIN SUCH ASSISTANCE AND WILL ASSIGN OR PAY TO THE HOSPITAL THE AMOUNT RECOVERED FOR HOSPITAL CHARGES. IF ANY INFORMATION I HAVE GIVEN PROVES TO BE UNTRUE, I UNDERSTAND THAT THE HOSPITAL MAY RE-EVALUATE MY FINANCIAL STATUS AND TAKE WHATEVER ACTION BECOMES APPROPRIATE.

DATE OF REQUEST _____ APPLICANT'S SIGNATURE _____

ELIGIBILITY DETERMINATION (For Office Use Only)

DATE APPLICATION RECEIVED:	SUBMITTED BY:
INCOME VERIFIED: ☐ YES ☐ NO	TYPE OF VERIFICATION:

☐ THE APPLICANT IS APPROVED ☐ / CONDITIONALLY APPROVED ☐ FOR CARE AT NO CHARGE ☐ OR A REDUCTION OF _____ % OF ALLOWABLE CHARGES UNDER CATEGORY B OF THE POVERTY INCOME GUIDELINES. AMOUNT PROVIDED AS UNCOMPENSATED SERVICES IS _____.
CONDITION(S) IF APPLICABLE: _____

☐ THE APPLICANT'S REQUEST FOR FREE OR REDUCED CHARGE SERVICES HAS BEEN DENIED FOR THE FOLLOWING REASONS: _____

DATE OF CONDITIONAL DETERMINATION:	DATE OF FINAL DETERMINATION:
DATE APPLICANT NOTIFIED:	APPROVED BY: