Charity Care and Discount
Financial Disclosure

To Whom It May Concern:

Attached you will find the application for financial assistance under AB774. This application is a financial disclosure document which must be completely filled out along with the following documents attached.

> Three copies of the most recent pay stubs of all parties working that live in the household.
> **OR**
> A Copy of the most recent tax return of all parties working that live in the household.

Please note this financial information must be identified for all parties living in the household and not just the patient.

The information presented will be reviewed against the criteria identified in the Charity Care and Discount Policies. Upon review of the above identified information a decision will be made as to whether or not you qualify for assistance.

The information you are presenting is an application and other financial disclosure information and not a guarantee of approval. The information presented will be reviewed and analyzed in a timely manner.

Please give a minimum of three to four weeks before a ruling will be made on your application.

If you have any questions please call the Director of the Business Operations at, (805) 737-3321.

Lompoc Healthcare District
•LOMPOC HOSPITAL •CONVALESCENT CARE CENTER
Over 60 Years of Caring for our Community

Serving the Lompoc Valley since 1943

Lompoc Healthcare District AB774 Demographic Data Sheet

Name_____ Date_____
Last (Appelido) First (Nombre) (Fecha)

Social Security Number_____ Birthdate_____
(Numero de seguro social) (Fecha de nacimiento)

Address_____
(Domicilio)

City_____ Zip_____
(Cuidad) (Zona postal)

Phone Number_____

Other Information:

Ethnicity (Circle One)

1. White
2. Black
3. Hispanic
4. Native American
5. Chinese
6. Japanese
7. Filipino
8. Indochinese
9. Pacific Islander
10. Other_____

Sex: Male (Hombre) Female (Mujer)

Family Size_____ (as reported on tax return)

Monthly Income_____

Primary Source of Income:

1. Professional/Technical
2. Labor/Production
3. Agriculture
4. Service
5. Unemployment
6. Retirement
7. Disability
8. General/Public Assist
9. Other_____
10. None
11. Unknown

Third Party Coverage:

1. None
2. Medicare
3. Self Pay
4. MediCal
5. Private Insurance
6. Other_____
7. Unknown

Financial Disclosure For AB774

Patient Name_____ Account_____

Social Security Number_____ Date of Birth_____

Address_____

Guarantor_____ Relationship_____

Social Security Number_____

Employer_____ Phone Number_____

Job Title_____ Salary_____

Spouse_____ Employer_____

Social Security Number_____ Salary_____

Other Family Members:

Name_____ Age_____

Name_____ Age_____

Name_____ Age_____

Other Income:

Source_____ Amount_____

Source_____ Amount_____

Assets:

Home_____ Own/Rent Auto_____

Bonds_____ Insurance_____

Bank Accounts:

Checking:

Bank_____ Account#_____ Balance_____

Bank_____ Account#_____ Balance_____

Savings:

Bank_____ Account#_____ Balance_____

Bank_____ Account#_____ Balance_____

Stocks/Bonds: Company_____ Value_____

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Financial Disclosure For AB774

(Monthly Payments or Expenses)

House Payment/Rent_____ Auto_____

Utilities_____ Food_____

Insurance_____

Other (Please Specify)_____

_____

_____

Comments_____

_____

_____

The above information is accurate and correct to the best of my ability, and I hereby grant Lompoc Healthcare District and/or their representative permission to verify this information.

I also understand that I am to submit the appropriate documents as required by the District which will reveal household wages, deductions and net wages, for a designated time period.

_____ _____
Signature of Patient Date

_____ _____
Parent/Guardian Date

_____ _____
Spouse (if applicable) Date

_____ _____
Received by Lompoc Healthcare District Date