

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.

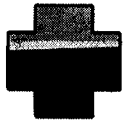
Please note this financial information must be identified for all parties living in the household and not just the patient.

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 (Apellido) First (Nombre) (Fecha)

Social Security Number _____ Birthdate _____
(Numero de seguro social) (Fecha de nacimiento)

Address _____
(Domicilio)

City _____ Zip _____
(Ciudad) (Zona postal)

Phone Number _____

Other Information:

Ethnicity (Circle One)

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

Sex: Male Female
(Hombre) (Mujer)

Family Size _____ (as reported on tax return)

Monthly Income _____

Primary Source of Income:

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

Third Party Coverage:

- | | | |
|-------------|----------------------|------------|
| 1. None | 4. MediCal | 7. Unknown |
| 2. Medicare | 5. Private Insurance | |
| 3. Self Pay | 6. Other _____ | |

508 EAST HICKORY AVENUE - P.O.BOX 1058 - LOMPOC, CA 93438 - (805) 737-3300



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 _____

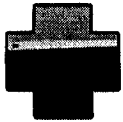
Bank _____ Account# _____ Balance _____

Savings:

Bank _____ Account# _____ Balance _____

Bank _____ Account# _____ Balance _____

Stocks/Bonds: Company _____ Value _____



Lompoc Healthcare District

● LOMPOC HOSPITAL ● CONVALESCENT CARE CENTER

Over 60 Years of Caring for our Community

Serving the Lompoc Valley since 1943

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

508 EAST HICKORY AVENUE - P.O.BOX 1058 - LOMPOC, CA 93438 - (805) 737-3300