

**Sherman Oak Hospital**

5000 Van Nuys Blvd #325 ♦ Sherman Oaks, California 91403 ♦ (818) 501-0434

Application for Uncompensated Care/Charity/Indigent Care  
To be Completed by Financial Responsible Party

Please complete this application in its entirety.

Date: \_\_\_\_\_ Account Number: \_\_\_\_\_

Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Spouse Employer: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City / State: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_

Social Security Number \_\_\_\_\_ Spouse Social Security Number: \_\_\_\_\_

Guarantor Name: \_\_\_\_\_

Guarantor Employer \_\_\_\_\_

Guarantor Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Guarantor Social Security Number \_\_\_\_\_

As provided for in Federal Law, I hereby request that SHERMAN OAKS HOSPITAL make a determination of my eligibility for uncompensated services. I understand that the information that I submit concerning my annual income and family size is subject to verification by the hospital. I also understand that if the information is determined to be false, such determination will result in a denial of providing services as uncompensated services, and that I will be liable for charges for services provided.

**Please fill out the following:**

**Total for last 12 months**

	<b>Patient</b>	<b>Spouse</b>
Wages:	\$ _____	\$ _____
Social Security	\$ _____	\$ _____
Strike Benefits	\$ _____	\$ _____
Alimony/Child Support	\$ _____	\$ _____
Military Allotment	\$ _____	\$ _____
Dividends/Interest	\$ _____	\$ _____
Pensions	\$ _____	\$ _____
Unemployment	\$ _____	\$ _____
Disability	\$ _____	\$ _____
IRA	\$ _____	\$ _____
Trust Account	\$ _____	\$ _____
Interest Income	\$ _____	\$ _____
Other	\$ _____	\$ _____

**Proof of income attached: { } W-2 Form { } Pay check stubs { } Tax Return**

**Expenses:**

House/Rent Payment \$ \_\_\_\_\_

Food: \$ \_\_\_\_\_

Water: \$ \_\_\_\_\_

Gas &amp; Electricity: \$ \_\_\_\_\_

Trash: \$ \_\_\_\_\_

Child Support: \$ \_\_\_\_\_

Auto Expenses: \$ \_\_\_\_\_

Insurance: \$ \_\_\_\_\_

**Credit Cards:**

Company: \_\_\_\_\_ Balance Owing: \$ \_\_\_\_\_

Amount Available: \$ \_\_\_\_\_

Company \_\_\_\_\_ Balance Owing: \$ \_\_\_\_\_

Amount Available: \$ \_\_\_\_\_

Company \_\_\_\_\_ Balance Owing: \$ \_\_\_\_\_

Amount Available: \$ \_\_\_\_\_

**Medical Bills:**

Hospital/Doctor Names \_\_\_\_\_

Amount: \$ \_\_\_\_\_

**Number of family members in household:** \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Bank References:**

Checking: Name/Branch: \_\_\_\_\_ Account # \_\_\_\_\_

Savings: Name/Branch \_\_\_\_\_ Account # \_\_\_\_\_

**Assets:**

Do you own your own Home? \_\_\_\_\_ Value: \_\_\_\_\_

Do you own other property? \_\_\_\_\_ Value: \_\_\_\_\_

Do you own your own automobiles? \_\_\_\_\_ Value \_\_\_\_\_

I agree that my physician may be informed of the status of this application for uncompensated care.

I understand that I may be asked to prove my statements and that my eligibility statement will be subject to verification by contact with my employer, bank, credit verification and property searches.

**I affirm that the statements made herein are true and correct to the best of my knowledge.**

**Signature of applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_