El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital
Charity Care Application

Account Number(s)_____

Patient's Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

County _____ Marital Status _____

SSN # _____ Phone # _____

No. of Dependents_____

Name of Spouse _____ Ages_____

Name of Parent(s)/Guardian(s) Employer Name/Address/Telephone

_____ _____

Annual family income: $ _____ _____

(please attach copies of most recent pay stubs or income tax returns) _____

Have you applied for Medi-Cal?	☐ Yes	☐ No
Are you under 21 years of age?	☐ Yes	☐ No
Are you 65 years of age or older?	☐ Yes	☐ No
Are you legally blind?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you unable to work because of a physical or mental illness or disability that is expected to last longer than one year?	☐ Yes	☐ No
Do you have a minor child under 21 years of age in your home?	☐ Yes	☐ No
Do you have Medicare?	☐ Yes	☐ No
Do you have Health Insurance?	☐ Yes	☐ No
If yes, please list _____		
Do you live in a nursing home?	☐ Yes	☐ No
Are you a veteran or a dependent of a veteran?	☐ Yes	☐ No
Are you being treated as a victim of a crime incident?	☐ Yes	☐ No
Are you being treated for a Workers Comp injury?	☐ Yes	☐ No

List all sources of assistance available to the patient

Medicare	☐ Yes	☐ No
Medi-Cal	☐ Yes	☐ No
Commercial Insurance Coverage	☐ Yes	☐ No
Out-Of-Country Insurance, explain below coverage limitations	☐ Yes	☐ No
Community Services, list source below	☐ Yes	☐ No
Family, list source below	☐ Yes	☐ No

Comments: _____

_____

Patient's Name_____ Date _____

Requesting Charity Care For: (Check all that apply)

- ☐ Total charges on patient bill(s) $_____
- ☐ Co-insurance/Co-payment $_____
- ☐ Deductible(s) $_____
- ☐ Other patient liabilities (non-covered items) $_____
- ☐ Medi-Cal Share of Cost $_____

If your insurance company is paying a portion of your bill, please complete the following and attach copies of the supporting receipts, invoices, bills, or other documentation.

Out-of-pocket expenses incurred by you at El Camino Hospital within 12 month period of application:*
$_____ *Out-of-pocket expenses are all patient bill balances, co-insurance, co-payment, or deductibles incurred at El Camino Hospital by the patient.

*Out-of-pocket medical expenses** paid by you or your family within 12 month period of application:* $_____ **Out-of-pocket medical expenses are any medical expenses paid by the patient or the patient's family, including expenses paid for physician services, hospital services, drugs, and any other medical services.

A patient's family is defined as a patient's spouse, domestic partner, and dependent children under 21 years of age. For patients under 18 years of age, their parent(s), caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

I attest that the financial information I have provided is complete and accurate and I agree that El Camino Hospital may verify this information. I agree to notify Patient Accounts of any changes in my financial circumstances and to provide upon request, insurance eligibility status.

I agree that El Camino Hospital may disclose the information contained on this application to any third party who may help fulfill my request for charity care or financial need discounts.

Patient's Signature _____ ***Date*** _____

Representative for Patient Signature _____ *Relationship* _____