Exhibit C
Watsonville Community Hospital
Charity Care/Financial Assistance Program Application

Patient Account Number:_____ Date of Application_____

PATIENT INFORMATION

Name_____

Address_____

City_____

State/Zip_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work Phone_____

Length of Employment_____

Supervisor_____

PARENT/GUARANTOR/SPOUSE

Name_____

Address_____

City_____

State/Zip_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work Phone_____

Length of Employment_____

Supervisor_____

RESOURCES

Checking: yes___ no___
Savings: yes___ no___

Cash on hand: $_____

Vehicle 1: Yr_____ Make_____ Model_____
Vehicle 2: Yr_____ Make_____ Model_____
Vehicle 3: Yr_____ Make_____ Model_____

Exhibit C (continued)
Charity Care/Financial Assistance Program Application

INCOME

Patient/Guarantor:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

Spouse/Second Parent:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

LIVING ARRANGEMENTS

Rent_____ Own_____ Other(explain)_____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment $_____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:

Proof of Income: Prior year income tax return, last 4 pay check stubs, letter from employer, Social Security, etc. Last 3 months bank statements. Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant_____

Hospital Representative Completing Application: _____

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Approval/Authorization of Charity Write-Off

Amount Approved $_____

BOM_____

CEO_____

CFO_____