Attachment B
Mendocino Coast District Hospital
Application for Charity Care Assistance
Date _____

Section A

1. Patient's Name_____
Last First Middle

2. Home Address_____
_____
City State Zip

3. Phone Number _____SS# _____Date of Birth_____

4. Employer_____
_____
Name Address

5. Employer Phone Number (____)_____How Long? _____Occupation_____
Yrs/Mon

6. Other Employment_____
_____
Name Address Phone

Section B Spouse, Parent or Guarantor Information (If Applicable)

1. Spouse, Parent or Guarantor Name_____

Last First
Middle

2. Home
Address_____
_____
City
State Zip

3. Phone Number _____SS#
_____Date of Birth_____

4.
Employer_____
_____
Name Address

5. Phone Number _____How Long
_____Occupation _____

6. Other
Employment_____
_____
Name Address
Phone

Section C **Other Parent Information (If Applicable)**

1. Spouse, Parent or Guarantor
Name_____
Last First
Middle

2. Home
Address_____
_____
City
State Zip

3. Phone Number _____SS#
_____Date of Birth_____

4.
Employer_____
_____
Name Address

5. Phone Number _____How Long
_____Occupation _____

6. Other
Employment_____
_____
Name Address
Phone

Section D **Dependent Information**

Full Name	Date of Birth	Social Security Number	Dependent Lives in Household Yes or No

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Section E **Income Information**

Source Of Income	Gross Amount	Monthly or Weekly
1. Employment Patient	$	

2. Employment Spouse, Parent or Guarantor	$
3. Alimony Received	$
4. Child Support Received	$
5.	$
5. Disability SSI/AFDC (Medi-Cal)	$
6. Food Stamps Received	$
7. Interest and Dividend Income	$
9.	$
8. Regular Income from Operation of Business or Profession	$
9. Other Income-----Specify Source	$

Section I **Asset Information**

Description	What is Current Value	What is Ow
1. Cash, Savings, Checking Accounts	$	$
2. Certificate of Deposits (CD's)	$	$
3. U.S. Savings Bonds, US Treasury Bonds/Bills	$	$
4. Stocks Mutual Funds (Name, Number of Shares)	$	$
	$	$
	$	$
5. Corporate/Municipal Bonds	$	$
6. Life Insurance Policies (Cash Value)	$	$
7. Collectibles (Stamps, Coins, Jewelry, Art)	$	$

8. Real Estate (Other than Primary Residence)	$	$
9. Business	$	$
10. Farm	$	$
11. Vehicles (Year, Make and Model)	$	$
Auto, Motorcycles, Recreational Vehicles, Boats	$	$
12. Other Assets (Be Specific)	$	$
13. Does anyone owe you money?	$	$

Section J **Attestation Statement**

I hereby certify that the information provided is true and correct to the best of my knowledge. I understand that providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree. I authorize Mendocino Coast District Hospital to contact my creditors, former and present employers, in order to verify this information.

_____

_____

Date Applicant's Signature

_____

_____

Date Witness Signature

Section F **Banking Information**

1. Name of Bank/Credit Union/Other Financial Institute_____

2. Checking Account Yes or No _____Savings Account Yes or No Other Yes or No_____

Section G **Housing Information**

1. Do you own your own home? Yes or No Mortgage Payment_____ Amount Owed_____

2. What is the estimated value? _____Do you rent? Yes or No Monthly Rent _____

Section H **Paid Medical Expenses**

1. Out-of-pocket medical expenses for the past 12 months____ Amount Paid_____
SUPPORTING DOCUMENTATION REQUIRED