Healthsouth Tustin Rehabilitation Hospital
Charity Care Application Form

1. Applicant Information.
Last Name First Name MI
Street Address
Telephone Numbers
Home
Work
Cell
City State Zip Code Mailing Address (if different from Street Address)
Date of Birth _ Male _ Female / Are you pregnant? Yes _ No _
Are you: homeless? Yes _ No _
unemployed? Yes _ No _
uninsured? Yes _ No _

2. If you are applying for someone else, complete this section.
Last Name First Name MI Relationship to Applicant:
Street Address Telephone Numbers
Home
Work
Cell
City State Zip Code Mailing Address (if different from Street Address)

3. Family Information. List the people in your family that live with you and you support with your income. Include your spouse, dependent children under age 18, and dependent elders that live with you. If this application is for a child under age 18, include brothers or sisters under 18 and the child's parent or parents who live with you.

Name of Family Member	Relationship	Date of Birth	Gender	Pregnant
			M _ F _	Y _ N _
			M _ F _	Y _ N _
			M _ F _	Y _ N _
			M _ F _	Y _ N _
			M _ F _	Y _ N _

4. List Earned Income before taxes and deductions for each family member who works.
Name of Working
Family Member
Employer Name & Address Amount
Earned
How Often?
Weekly/Monthly/Annually

5. Other Income not from an employer.
Type of Income Family Member
Receiving Income
Amount How often?
Weekly/Monthly/Annually
Social Security
Railroad Retirement
Veterans' Benefits

Retirement Funds
Annuities
Pensions
Child Support
Alimony
Unemployment
Workers Compensation
Rental Income
Trust Income
County General Relief
Refugee Resettlement Program
Dividend Income
Bank Account Income
Other Income, please specify

6. Other Expenses. Fill in this section if you or anyone in Section 3 is required to make payments for alimony, child support, or personal needs allowance for a family member in a nursing home.
Payment Type Recipient
Name/Relationship
Amount Paid How often?
Weekly/Monthly/Annually
Alimony
Child Support
Personal Needs Allowance

7. Other Insurance. Charity Care can pay for such things as your co-payments and deductibles even if you have other health insurance
a. Are you covered under any health insurance program, including Medicare? Y _ N _ If yes:
Policy Holder (Name) Insurance Company Policy Number
b. Are you seeking Charity Care because of a work-related accident or injury? Y _ N _
c. Are you seeking Charity Care because of a car accident? Y _ N _
d. Are you a student? Y _ N _ If yes, are you full time? _ part time? _
e. Do you have an application pending for any of these programs? *(Check all that apply)*
Medicaid _
Medicare _
f. Are you currently approved for Charity Care at another hospital or community health center?
Y _ N _ If yes, where?_____

8. Medical Bills. Total medical bills _____
Why can't you pay your medical expenses? Why do you need Charity Care?
_____
_____
_____
_____
_____

9. Ethnicity/Race. Ethnicity/Race will not be used to determine eligibility.
- ❑ Asian or Pacific Islander
- ❑ African-American, not Latino
- ❑ Latino

- ❑ American Indian or Alaskan Native
- ❑ Caucasian, not Latino
- ❑ Other_____
- ❑ I do not wish to answer.

This is for data collection and analysis purposes only.

10. Assignment of Rights. Read this section carefully and sign.

I agree to tell this hospital about changes to my family status including family size, income, and insurance coverage that could change my eligibility for Charity Care.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request.

_____ _____

Signature of applicant Date

_____ _____

Signature of authorized representative Date

If you have questions about this application, contact the Charity Care Representative at 714/832-9200

Mail the completed application to:

Charity Care Processing
Healthsouth Tustin Rehabilitation Hospital
14851 Yorba Street
Tustin CA 92780