Good Samaritan Hospital
A Tradition of Caring

1225 Wilshire Boulevard, Los Angeles, California 90017-2395 • Tel. (213) 977-2121 Ext. 2700

Financial Assistance Form (Forma de Ayuda Financiera)

Patient Account# (# de Cuenta del Paciente): _____

PATIENT'S INFORMATION (INFORMACION DEL PACIENTE)

Name (Nombre): _____

Spouse Name (Nombre del Esposo(a)): _____

Address (Direccion): _____

Telephone # (Telefono): _____

SSN (Numero de Seguro Social): _____

Spouse's SSN (Numero de Seguro Social del Esposo(a)): _____

PATIENT'S EMPLOYMENT INFORMATION (INFORMACION DE SU TRABAJO DE PACIENTE)

Place of Employment (Lugar de Trabajo): _____

Employment Address (Direccion): _____

Employment Telephone# (Telefono): _____

Occupation (Ocupacion): _____

SPOUSE INFORMATION (INFORMACION DE SU ESPOSO(A))

Place of Employment (Lugar de Trabajo): _____

Employment Address (Direccion): _____

Employment Telephone# (Telefono): _____

Occupation (Ocupacion): _____

INSURANCE INFORMATION (INFORMACION DE SU ASEGURANZA)

Do you have Health Insurance (Tiene Aseguranza de Salud)? YES____ NO ____

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Insurance Name (Nombre de Aseguranza): _____

Subscriber Name (Nombre del Aseguranza): _____

ID# (Numero de ID): _____ GRP# (Numero de Groupo): _____

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DEPENDENTS (DEPENDIENTES)

Name (Nombre): _____ Age (Edad): ____ Relationship (Relacion): _____

Name (Nombre): _____ Age (Edad): ____ Relationship (Relacion): _____

Name (Nombre): _____ Age (Edad): ____ Relationship (Relacion): _____

FINANCIAL INFORMATION (INFORMACION FINANCIERA)

Checking/Saving Account (Cuenta de Cheques/Ahorro): Yes _____ No_____

Credit Cards: Yes____ No_____

If yes, list type of credit cards and balances: _____

_____

INCOME INFORMATION (INFORMACION DE INGRESO)

Net Family Household Income/per month (Ingreso Neto por Familia/Mensual): _____

Other Income (Otros Ingresos): _____

MONTHLY EXPENSES (GASTOS MENSUALES)

Are you a Home Owner? YES _____ NO _____

Rent (Renta): _____ Utilities (Utildades): _____

Landlord's Name (Nombre del Propietario): _____

Child Care (Cuidados de Ninos): _____

Other Expenses (Otros Gastos): _____

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PLEASE NOTE THAT ALL INFORMATION PROVIDED MUST BE ACCURATE TO ENABLE US TO DETERMINE YOUR FINANCIAL STATUS AND TO ASSIST YOU. (LA INFORMACION QUE NOS PROVEA DEBE SER CORRECTA PARA PODER DETERMINAR SU SITUATION FINANCIERA Y ASI PODER AYUDARLE).

THE COMPLETE FORM MUST BE RETURNED NO LATER THAN: _____

(REGRESE LA FORMA COMKPLETA A MAS TARDE): _____

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IN ORDER TO PROCESS YOUR APPLICATION FOR FINANCIAL ASSISTANCE THE FOLLOWING DOCUMENTATION MUST BE SUBMITTED FOR VERIFICATION PURPOSES (PARA PODER CONSIDERAR SU APLICACION DE AYUDA FINANCIERA, DEBE PRESENTAR LA SIGIENTE DOCUMENTACION PARA QUE SEA VERIFICADA):

- **Copy of Drivers License or Other Government Valid Identification (copia de licencia de manejo)**
- **Current Paycheck Stub (Talon de Cheque Mas Corriente)**
- **Current Bank Statements (Estado Bancario Mas Corriente)**
- **Rent/Utilities Receipts (Recibo de Renta y Utilidades**
- **Current Income Tax Return/W-2 Form (Forma de Impuestos/Forma W-2)**
- **Notarized Letter for Missing Documents**
- **Other: _____**

_____

AUTHORIZATION TO RELEASE INFORMATION (AUTHORIZATION PARA DISEMINAR INFORMACION

This authorization is for use or disclosure of medical, personal and financial information to assist in determining your financial ability to pay. All information obtained will be protected under the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, effective April 14, 2003.

I understand this information will be released to designated hospital personnel. The sole purpose of this release of information is to evaluate and render a determination on my application for financial assistance for uncompensated services (entiendo que mi informacion sera usada por el personal designado del hospital. El unico proposito de esta informacion es para evaluar y tomar una decision con respecto a mi applicacion).

SIGNATURE (FIRMA): _____

NAME (NOMBRE): _____

RELATIONSHIP TO PATIENT (RELACION CON EL PACIENTE): _____

DATE (FECHA): _____