

Encino Hospital Medical Center

4911 Van Nuys Blvd #300 ♦ Sherman Oaks, California 91403 ♦ (818) 501-0434

Application for Uncompensated Care/Charity/Indigent Care
To be Completed by Financial Responsible Party

Please complete this application in its entirety.

Date: _____ Account Number: _____

Name: _____

Patient Name: _____ Spouse Name: _____

Patient Employer: _____ Spouse Employer: _____

Patient Address: _____

City / State: _____

Phone Number: _____

Date of Birth: _____ Spouse Date of Birth: _____

Social Security Number _____ Spouse Social Security Number: _____

Guarantor Name: _____

Guarantor Employer _____

Guarantor Address: _____ Phone Number: _____

Guarantor Social Security Number _____

As provided for in Federal Law, I hereby request that ENCINO HOSPITAL MEDICAL CENTER make a determination of my eligibility for uncompensated services. I understand that the information that I submit concerning my annual income and family size is subject to verification by the hospital. I also understand that if the information is determined to be false, such determination will result in a denial of providing services as uncompensated services, and that I will be liable for charges for services provided.

Please fill out the following:

Total for last 12 months

| | Patient | Spouse |
|-----------------------|----------------|---------------|
| Wages: | \$ _____ | \$ _____ |
| Social Security | \$ _____ | \$ _____ |
| Strike Benefits | \$ _____ | \$ _____ |
| Alimony/Child Support | \$ _____ | \$ _____ |
| Military Allotment | \$ _____ | \$ _____ |
| Dividends/Interest | \$ _____ | \$ _____ |
| Pensions | \$ _____ | \$ _____ |
| Unemployment | \$ _____ | \$ _____ |
| Disability | \$ _____ | \$ _____ |
| IRA | \$ _____ | \$ _____ |
| Trust Account | \$ _____ | \$ _____ |
| Interest Income | \$ _____ | \$ _____ |
| Other | \$ _____ | \$ _____ |

**Proof of income attached: { } W-2 Form { } Pay check stubs { } Tax Return
 { } Hardship Letter**

Expenses:

House/Rent Payment \$ _____

Food: \$ _____

Water: \$ _____

Gas & Electricity: \$ _____

Trash: \$ _____

Child Support: \$ _____

Auto Expenses: \$ _____

Insurance: \$ _____

Credit Cards:

Company: _____ Balance Owing: \$ _____

Amount Available: \$ _____

Company _____ Balance Owing: \$ _____

Amount Available: \$ _____

Company _____ Balance Owing: \$ _____

Amount Available: \$ _____

Medical Bills:

Hospital/Doctor Names _____

Amount: \$ _____

Number of family members in household: _____

Name: _____ Relationship _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Bank References:

Checking: Name/Branch: _____ Account # _____

Savings: Name/Branch _____ Account # _____

Assets:

Do you own your own Home? _____ Value: _____

Do you own other property? _____ Value: _____

Do you own your own automobiles? _____ Value _____

I agree that my physician may be informed of the status of this application for uncompensated care.

I understand that I may be asked to prove my statements and that my eligibility statement will be subject to verification by contact with my employer, bank, credit verification and property searches.

I affirm that the statements made herein are true and correct to the best of my knowledge.

Signature of applicant: _____ **Date:** _____

Witness: _____ **Date:** _____

Revised 5/05/2020