Encino Hospital Medical Center

Financial Assistance Application Form

Application Date:	Date of Service:	
Patient Name:	Account Number:	
Street Address:		Phone Number:
City, State, ZIP:		Patient Date of Birth:

Please call 818-501-0434 for any questions about filling out this form.

1) Was the patient a resident of California at the time of service? Yes____ No____
2) Did the patient have medical insurance at the time of service? Yes____ No____
3) Was the patient an active Medicaid recipient at the time of service? Yes____ No____

**If you answered *yes* to questions 2 or 3, please attach a copy of your insurance or Medicaid card to this application.

INCOME:

- **All adult family members' income must be disclosed.** Income includes gross (before taxes) wages, rental income, unemployment compensation, social security benefits, public assistance, dividends and interest, etc.

- "Family" is defined as follows: (i) for persons 18 years of age and older, family means spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (ii) for persons under 18 years of age, family means parents, caretakers, relatives, and other children under 21 years of age of the parent or caretaker relative. If the patient is a minor, the "family" is defined as the patient, the patient's natural or adoptive parents and the parent's other children (natural or adoptive) who live in the patient's home.

Family Member's Name	Age	Date of Birth	Relationship to Parent	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service
			Self			

- **Proof of income must be supplied at the time of application (e.g., three months of pay stubs, most recent tax return (IRS Form 1040), etc.).**

- If you report $0 income, please provide a written statement of how you (or the patient) are surviving financially, including who provides food, shelter, transportation, etc. and how long you have been without income.

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MONTHLY EXPENSES:			ASSETS: This information may be used if your income is above 200% of Federal Poverty Level guidelines to determine whether you may be eligible for discounted care.	
Monthly rent/mortgage	**$_____**		**Checking account**	**$_____**
Utilities	**$_____**		**Savings account**	**$_____**
Car payment	**$_____**		**Business ownership**	**$_____**
Medical expenses	**$_____**		**Stocks and bonds**	**$_____**
Insurance premiums (life, home, car, medical)	**$_____**		**Real estate (excluding primary residence)**	**$_____**
Clothing, groceries, household goods	**$_____**			
Other debt/expenses (e.g., child support, loans, other)	**$_____**			

My signature below certifies that everything I have stated on this application is correct and subject to review under audit. I understand that if the information I provide is determined to be false, financial assistance may be denied and I may be responsible to pay for services provided.

Applicant's Signature

Date

Please return completed application to:

Encino Hospital Medical Center
Attn: Patient Financial Services
16237 Ventura Boulevard
Encino, CA 91436

Revised October 2018