LADMC LA Downtown Medical Center LLC

West Covina Medical Center

FINANCIAL ASSISTANCE APPLICATION

Request for Uncompensated Services

Program Distinction Notice:
This single application may be used to apply for either the Charity Care or Discount Payment program. Patients who qualify for Charity Care may receive greater financial assistance, including up to a 100 percent write-off of eligible hospital charges, than patients who qualify only for the Discount Payment program.

Please check the program for which you are applying:
☐ Charity Care ☐ Discount Payment

Location (select one):
☐ West Covina Medical Center ☐ L.A. Downtown Medical Center

If unsure which program to apply for, please contact the Business Office for assistance.Date of Service: _____

Name: _____Sex Code: ☐ 1-Male ☐ 2-Female

Date of Birth: _____
Address: _____
City/State/Zip: _____
Telephone: (_____) _____

Ethnicity: Enter code as follows:
Code: _____
(1) White
(2) Black
(3) Hispanic
(4) Native American/Eskimo
(5) Asian/Pacific Islander
(6) Other

Family Principle Income Source (select one)
Code: _____
(1) Professional/Technical
(2) Labor/Production
(3) Agricultural
(4) Service/Sales
(5) Unemployment
(6) Retirement
(7) Disability
(8) General Relief
(9) Other
(10) None

Family Size:

Name:	Age	Sex

Potential 3rd Party Payor Source

Code:_____
(1) Private Insurance
(2) Medi-Cal
(3) Medicare
(4) Self-Pay
(5) Other
(6) None

INCOME: List Income for family from: **Monthly/Annual**

Wages (Self)

(Spouse) _____
(other Family Members) _____
Farm or self-employed _____
Public Assistance _____
Social Security _____
Unemployment-compensation---- _____
Worker's Compensation _____
Strike Benefits _____
Alimony _____
Child Support _____
Military Family Allotments _____
Pensions _____
Income from Dividends, Interest, Rent _____

Type of Service: Code:____
1) Hospital Inpatient
2) Hospital Outpatient

Unit of Service
I/P Days _____
O/P Days _____

Billed Amount $_____
Repayment Collected $_____
Other Write-Offs $_____
Patient Liability $_____

Date of Service:_____

Expenses (Monthly)

Mortgage/Rent $ _____
Medical Insurance $ _____
Utilities $ _____
Auto Insurance $ _____
Telephone $ _____
Medical Bills $ _____
Food $ _____
Hospital $ _____
Finance Companies $ _____
Physicians $ _____
Credit Union $ _____
Medications $ _____
Auto Loans $ _____

Total Expenses: $ _____

Note: Only monetary assets (such as cash, checking, savings, and investment accounts) are considered in determining eligibility for financial assistance. Questions regarding non-liquid assets (including home, property, or automobile values) are not required and are excluded from eligibility determination

BANK REFERENCES:

Name/Branch: _____ Account# _____

Name/Branch: _____ Account# _____

Total Net value of all items in this section:

Liability Computation

Plus Total Monthly Gross Income Minus Monthly Deductions Income	(A)_____Adjusted Net Monthly (B)_____ A-B_____

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge

I agree to tell the provider of service within ten (10) days of there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses or in the persons in the household or any change of address.

I understand the county is required by law to keep any information I provide confidential.

I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county from the proceeds of any litigation or settlement resulting from such act.

_____ _____

Signature Date

For Hospital Use Only:_____Accepted _____Denied

Comments:

Signature Date