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.

Account Number: _____

Date: _____

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