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

Application for Uncompensated Care/Charity/Indigent Care

Account Number: _____

Date: _____

This is to notify you that you must make sure that when completing your application for discount or charity care that you send all necessary documents listed below with your application within 30days, or your application, will be denied:

1. **Signed financial hardship letter**
2. **Completed application**
3. **Signed authorization**
4. **Copies of last two pay stubs for patient and/or spouse**
5. **Copy of last two-year tax returns**
6. **Copies of last two months bank statements for patient and/or spouse**
7. **Copy of Medi-cal /SSI denial letter (if applicable)**
8. **Proof of Income from SSA (if applicable)**
9. **Proof of Income from Disability (if applicable)**

All the information must be completed accordingly. If this application is not completed and returned within 30 days we will resume collection efforts.

***A patient who has third party coverage or whose injury is a compensable injury for purposes of worker's compensation, automobile insurance, or other insurance as determined and documented by the hospital does not qualify for the Charity Care Program. ***

Respectfully,

Charity Care Representative
818-501-0434