HOLLYWOOD PRESBYTERIAN MEDICAL CENTER

Charity Care Screening Form

Request for Financial Assistance/Uncompensated Services

Hollywood Presbyterian Medical Center's (HPMC's) Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs with low-income, uninsured or underinsured, ineligible for a government program, and is otherwise unable to pay for medically necessary care based on their individual family financial situation.

To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance. Please complete the questionnaire below and return with copy(s) of your pay-check stub and bank statement.

Name _____ **Guarantor/Account #** _____

Address _____ **Phone number** _____

_____ **Social Security No.** _____

Date of Birth / / **Sex** _____ (M=Male/F=Female)

Number of dependents filed on tax return: _____

Do you own a home? **Yes** ☐ **No** ☐

Do you own other property? **Yes** ☐ **No** ☐

Do you own automobiles? **Yes** ☐ **No** ☐

List dependents:

Name	**Relationship**	**Age**	**Gender**

INCOME: (Please provide photocopies of pay-checks and bank statements and list income)

	Monthly	**Annual**
Wages (Self)		
(Spouse)		
(Other Family Member)		
Self-Employment		
Public Assistance		
Social Security		
Unemployment Compensation		
Retirement		
Alimony /Child Support		
Military Family Allotments		
Pensions		
Income from Dividends, Interest, Rent		

EXPENSES (Monthly)

Mortgage / Rent **(1)**	
Utilities	
Telephone	
Food	
Finance / other loans	
Auto Loans	
Other	
Total Expenses	

BANKING INFORMATION

Checking Account #	
Balance	
Savings Account #	
Balance	
Medical Bills	

(1) If none, source of housing: _____

- I declare under penalty of perjury that the answers I have given are true and correct to the best off my knowledge.
- I agree to tell the provider of services, within 10 days, if 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 of any change of addresses.
- I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with my employer, bank, credit verification and property searches.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the hospital from proceeds off any litigation or settlement resulting from such act.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the services rendered by UC Irvine Health or I may appeal decision in writing with additional documentation.

_____ _____

Signature **Date**