BARLOW RESPIRATORY HOSPITAL- FINANCIAL ASSISTANCE APPLICATION

This financial assistance application will be used to determine your eligibility for charity care or discounted medical services at our facility. You must complete this form and return it with copies of all the required documentation. If you have questions concerning the completion of this application or eligibility for our financial assistance programs, please contact our Financial Services Department at (213) 250-4200 ext.3329 or our remote Patient Financial Services Provider at (844-288-2025). This financial assistance application must be returned by: _________________.

The Application must be delivered to the Financial Services Department at our Barlow Main location, or mailed to:

BARLOW RESPIRATORY HOSPITAL
ATTENTION: PATIENT FINANCIAL SERVICES
2000 STADIUM WAY
LOS ANGELES, CA 90026-2696

Patient Name:______________________________ Spouse ____________________________

Address: ____

Home/Cell Phone: ___________________________ Work Phone ______________________

Patient Social Security #______________________ Spouse SS #: _______________________

Family Status – List all dependents that you support			
Name	Age	Relationship	Annual Income

<u>Existing Insurance</u>

Do you have any health insurance, such as Medicare, Medi-Cal or private health insurance?

Yes:____ No:_____ Insurer:____

Is your injury covered by workers' compensation, automobile insurance, or other insurance?

Yes:____ No:_____

Please provide any documentation in support of your answers above.

Employment Status

Employer ______________________________ Position_____________________________

Contact Person___________________________ Phone # ______________________________

Spouse Employer________________________ Position_______________________________

Family Income	**Qualified Assets**
Job related income	Checking accounts
Social Security	Savings accounts
Unemployment/disability	Primary Residence
Interest/dividends	Other real estate
Alimony	Stocks, Bonds, CDs
Child Support	Other:____________
Other income	Other:____________
TOTAL	TOTAL ASSETS

Please attach copies of the following:

-Copy of your prior year tax return and W-2 statement and copies of your last two paycheck stubs

-Copy of social security, public assistance, or unemployment check stubs for the prior two months

-Copy of unemployment compensation determination or denial notice

-Copy of checking, savings, or investment reports for prior two months.

Annual Medical Costs

How much have you paid in medical costs during the past 12 months to:

Barlow Respiratory Hospital:__________________ (please attach supporting documentation)

Other Providers:_____________________________ (please attach supporting documentation)

How much do you currently owe medical providers (other than BRH)_____________________
(please attach supporting documentation)

My signature on this form verifies the accuracy of the information provided and authorizes Barlow Respiratory Hospital to verify any and all information provided.

I understand that any financial assistance is intended solely for my benefit and does not relieve third parties of liability for payment.

I understand that if I do not qualify for financial assistance, I will be personally liable for the charges of the services rendered by Barlow Respiratory Hospital. It is also understood that I may appeal the determination of whether I qualify for financial assistance in writing with additional documentation.

_____________ ____

Date Signature of Patient or Legal Guardian

_____________ ____

Date Signature of Spouse