Sherman Oak Hospital
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 SHERMAN OAKS HOSPITAL 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

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.

SIGNED AUTHORIZATION BELOW

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