



Application for Uncompensated Care

SECTION 1.- FAMILY/GUARANTOR INFORMATION		SECTION IV.- NON-LIQUID ASSETS					
Total Number in Family:			Make	Year	Amount owed	Monthly payment	Value
# of Dependents Under 21:		Car 1					\$ _____
Name of Guarantor:		Car 2					\$ _____
Relationship to patient:		Other					\$ _____
Citizenship Status		Total					
		Do you own or rent residence?				<input type="checkbox"/> Own	<input type="checkbox"/> Rent
SECTION II.- GROSS MONTHLY INCOME		Do you own other property?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mother:		Address/Location:					
<input type="checkbox"/> Employment	\$ _____		Value	Amt Owed	Equity		
<input type="checkbox"/> Disability	\$ _____	Other property					
<input type="checkbox"/> Unemployment	\$ _____	TOTAL Non- LIQUID ASSETS:					\$ _____
<input type="checkbox"/> Retirement	\$ _____	SECTION V.- MONTHLY EXPENSES					
<input type="checkbox"/> Medi-cal	\$ _____		Mother	Father			
<input type="checkbox"/> Other:	\$ _____	Alimony and/or child support		\$ _____	\$ _____		
Father		Day Care Costs for Children		\$ _____	\$ _____		
<input type="checkbox"/> Employment	\$ _____	Health Insurance Premiums		\$ _____	\$ _____		
<input type="checkbox"/> Disability	\$ _____	Work expenses (\$75 per person max.)		\$ _____	\$ _____		
<input type="checkbox"/> Unemployment	\$ _____	Total Medical/Dental Expenses		\$ _____	\$ _____		
<input type="checkbox"/> Retirement	\$ _____	Charge Accounts/Loans/Credit Cards:		\$ _____	\$ _____		
<input type="checkbox"/> Medi-cal	\$ _____	Name:		\$ _____	\$ _____		
<input type="checkbox"/> Other:	\$ _____	Name:		\$ _____	\$ _____		
TOTAL INCOME:	\$ _____	Name:		\$ _____	\$ _____		
SECTION III.- LIQUID ASSETS		MasterCard Limit		\$ _____	\$ _____		
Checking Account #	\$ _____	Visa limit:		\$ _____	\$ _____		
Bank Name:		TOTAL EXPENSES		\$ _____	\$ _____		
Branch:		DOCUMENTS REQUIRED:					
Savings Account#:	\$ _____	<input type="checkbox"/> Last year's Tax Return or 3 months' worth of pay stubs					
Bank Name:		<input type="checkbox"/> Copy of bank statements {2 months}					
Branch:		<input type="checkbox"/> Rental receipt or mortgage payment {3 months}					
Other:	\$ _____	<input type="checkbox"/> Other: (specify)					
Specify							
TOTAL LIQUID ASSETS:	\$ _____						

PURPOSE: The purpose of this information is to determine your ability to pay for services at Children's Hospital LA, or your possible eligibility for a medical assistance program. This information is NOT an application for Medi-cal, and California Children's Services, County Medically Indigent Services Program or any other county's assistance program. You MUST CONTACT THE DEPARTMENT OF SOCIAL SERVICES IN YOUR COUNTY OF RESIDENCE TO APPLY FOR ASSISTANCE PROGRAMS.

I certify the above information to be accurate and complete. I understand that the hospital reserve the right to verify all information. I agree to notify Patient Business Services of any change in my financial information within 10 days of the change.

I UNDERSTAND THAT I AM STILL RESPONSIBLE FOR THE FULL AMOUNT OF MY CHARGES AT CHILDRENS HOSPITAL LOS ANGELES.

Signature of Parent/ Guardian

Date

Witness/ Translator

Hospital Representative