

**Barstow Community Hospital  
Charity Care/ Financial Assistance Program Application**

**Patient Account Number:** \_\_\_\_\_

**Date of Application:** \_\_\_\_\_

**PATIENT INFORMATION**

**PARENT/GUARANTOR/SPOUSE**

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

City \_\_\_\_\_

State/ZIP \_\_\_\_\_

State/Zip \_\_\_\_\_

SS# \_\_\_\_\_

SS# \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

City \_\_\_\_\_

State/Zip \_\_\_\_\_

State/Zip \_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Length of Employment \_\_\_\_\_

Length of Employment \_\_\_\_\_

Supervisor \_\_\_\_\_

Supervisor \_\_\_\_\_

**RESOURCES**

Checking: YES  NO

Vehicle 1: Yr \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

Savings: YES  NO

Vehicle 2: Yr \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

Cash on hand: \$ \_\_\_\_\_

Vehicle 3: Yr \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

**Charity Care/ Financial Assistance Program Application**

**INCOME**

Patient/ Guarantor:  
Wages (monthly): \_\_\_\_\_

Spouse/ Second Parent:  
Wages (monthly): \_\_\_\_\_

**OTHER INCOME**

Child Support: \$ \_\_\_\_\_  
VA Benefits: \$ \_\_\_\_\_  
Workers' Comp: \$ \_\_\_\_\_  
SSI: \$ \_\_\_\_\_  
Other: \$ \_\_\_\_\_

**OTHER INCOME**

Child Support: \$ \_\_\_\_\_  
VA Benefits: \$ \_\_\_\_\_  
Workers' Comp: \$ \_\_\_\_\_  
SSI: \$ \_\_\_\_\_  
Other: \$ \_\_\_\_\_

**LIVING ARRANGEMENTS**

Rent: \_\_\_\_\_ Own: \_\_\_\_\_ Other (explain) \_\_\_\_\_

Landlord/Mortgage Holder: \_\_\_\_\_

Phone Number \_\_\_\_\_ Monthly payment \$ \_\_\_\_\_

**REQUIRED DOCUMENTS**

The following documents must be attached to process your application for Charity Care/Financial Assistance:

- Proof of Income: Prior year income tax return, last 3 months bank statements, last 4 check stubs (if applicable), or a letter from employer, or letter from Social Security, etc.
- Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and sell phones.)
- Other documents as requested.

\*The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

*\*The hospital reserves the right to pull a copy of your credit report.*

**Signature of Applicant** \_\_\_\_\_

**Hospital Representative Completing Application** \_\_\_\_\_

**\*The below signatures are an indication of your review of the application and supporting documentation and that you find the information to meet policy requirements.**

**Approval/ Authorization of Charity Write-Off**

\$ \_\_\_\_\_

**BOM** \_\_\_\_\_

**Amount Approved:**

**CEO** \_\_\_\_\_

**CFO** \_\_\_\_\_