PIH HEALTH HOSPITAL REQUEST FOR FINANCIAL ASSISTANCE

I ask PIH Health Hospital to determine if I am eligible for assistance in paying for my hospital bill. I understand that I need to give certain information for this to be considered. I understand that filling out this form does not guarantee that I will receive this help. If I am not eligible for uncompensated services, I am responsible for my hospital bill.

Name _____ Account number _____

Address _____ Phone number _____
Street City Zip

Employer name _____ Employer phone # _____

Employer address _____

Date of birth ___/_____/_____ Sex Code ___ 1=Male 2= Female
Number of family members living with you _____

Name	Relationship	Age	Gender	Name	Relationship	Age	Gender

Physician Name _____ Diagnosis _____

INCOME: PLEASE PROVIDE PHOTOCOPIES OF CHECKS AND BANK STATEMENTS AND LIST INCOME

	Monthly	Annual
Wages (Self)		
(Spouse)		
(Other Family Member)		
Farm or self employment		
Public Assistance		
Social Security		
Unemployment Compensation		
Strike Benefits		
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 _____
(1) If none, source of housing _____

Medical Insurance _____
Auto Insurance _____
Medical Bills _____
Hospital _____
Physician _____
Medication _____
TOTAL EXPENSES _____

Do you own a home? Yes ( ) No ( ) If yes, estimated value: _____ Amount owed _____
Do you own other property? Yes ( ) No ( ) If yes, estimated value: _____
Do you own automobiles? Yes ( ) No ( ) If yes, Model/Make Year Value

- I declare under penalty of perjury that the answers I have given are true and correct to the best of 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 of 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 PIH Health Hospital or I may appeal decision in writing with additional documentation.

_____ _____

Signature Date

Please mail your completed application and attachments to: PIH Health P.O. Box 511216 Los Angeles, CA 90051