CHINESE HOSPITAL
845 JACKSON STREET, SAN FRANCISCO, CA 94133

Confidential Financial Statement (Financial Assistance Application)

Patient Name:	Date of Service:
Patient Number:	

Responsible Party

Name	Marital Status	Social Security Number
Street Address, City, State, Zip	How long at this address	Home Phone
Employer Name and Address		Business Phone
Position/Title	Monthly Income - Gross	Monthly Income – Net
Length of current employment		

SECTION A - For patients above 18 years or older only

Spouse or Domestic Partner (for patients above 18 years or older)

Name		Social Security Number
Employer Name and Address		Business Phone
Position/Title	Monthly Income – Gross $	Monthly Income – Net $
Length of current employment		

Dependents under 21 years of age

Name and Date of Birth of all Dependents in household	Total Number of Dependents

SECTION B - For patients below 18 years

Parent or Caretaker Relative (for patients under 18 years)

Name		Social Security Number
Employer Name and Address		Business Phone
Position/Title	Monthly Income – Gross $	Monthly Income – Net $
Length of current employment		

Additional Parent or Caretaker Relative (for patients under 18 years)

Name		Social Security Number
Employer Name and Address		Business Phone
Position/Title	Monthly Income – Gross $	Monthly Income – Net $
Length of current employment		

Other children under 21 years of age of the parent or caretaker relative.

Name and Date of Birth of all Children in household	Total Number of Children

SECTION C: For ALL Patients

Patient Family Income per Month

Employment Income	$	Workers' Compensation	$
Unemployment Benefits	$	Child Support/Alimony	$
Social Security	$	Rental Income	$
Disability	$	Other	$

Patient Family Expenses per Month

Mortgage / Rent Payment	$	Own Home? (Yes / No):	
Mortgage Balance	$		
Food	$	Medical / Dental	$
Utilities	$	Doctor – Name	$
Electric	$	Doctor – Name	$
Gas	$	Doctor – Name	$
Water / Sewer	$	Credit Cards	$
Trash	$	Visa Limit	$
Phone	$	MasterCard Limit	$
Cable	$	Discover Limit	$
Auto Payments	$	Other Limit	$
Auto Expenses	$	Installment Loans	$
Insurance	$	Child Support / Alimony	$
Auto Premium	$	Miscellaneous expenses	$
Life Insurance	$		
Health Insurance	$		

OFFICE USE ONLY
Gross Income _____
Net Income _____
Total Expenses _____
Total Net Income/(Loss) _____

To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.

_____
PATIENT/GUARANTOR
SIGNATURE / DATE

Verification of Income for Discount Care and Charity Care

(a) For purposes of determining eligibility for **Discounted Care**, documentation of income shall be limited to two most recent paystubs or recent income tax returns.
(b) For purposes of determining eligibility for **Charity Care**, documentation of income may include IRS Form W-2, SSA-1099, or other appropriate indicators of income. Alternatively, patients may submit documentation showing the patient's current participation in a public benefits programs including Social Security, Workers' Compensation, Unemployment Insurance Benefits, Medicaid, County Indigent Health, TANF, Food Stamps, WIC, or other similar indigence related programs.