27200 Calaroga Ave, Hayward, CA 94545

FINANCIAL ASSISTANCE/ CHARITY CARE POLICY	EXHIBIT B

STATEMENT OF FINANCIAL CONDITION/FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME _____ SPOUSE _____

ADDRESS _____

PHONE _____ SSN: _____

ACCOUNT # _____

(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION

Employer: _____ Position: _____

Contact Person & Telephone Number: _____

If Self-Employed the Name of Business: _____

Spouse Employer: _____ Position: _____

Contact Person & Telephone Number: _____

If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

		Patient	Spouse
	Gross Pay(Before Deductions)		
Add:	Income from Operating Business (ifSelf-Employed)		
Add:	Other Income Interest&Dividends From RealEstate Social Security Other (Specify) Alimony or Spousal Support	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Subtract:	Alimony, Support Payments Paid		
Equals	Current Monthly Income	_____	_____

Total Current Monthly Income (Patient & Spouse)=$_____

FAMILY SIZE

Total Family Members: _____

(add patient, spouse and dependents from above)

	Yes	No
Do you have health insurance?	____	
Are you eligible for any government programs?	____	
Do you have other insurance that may apply (such as auto policy)?		
Were your injuries caused by a third party? (such as during car accident)?		

By signing this form, I agree to allow St .Rose Hospital to check employment status and credit history for the purpose of determining my eligibility for financial assistance. I understand that I will be required to provide proof of the information I am providing.

_____ _____

(Signature of Patient or Guarantor) (Signature of Spouse) Date