St. Rose HOSPITAL

27200 Calaroga Avenue, Hayward, CA 94545

CHARITY CARE POLICY	EXHIBIT C

STATEMENT OF FINANCIAL CONDITION/FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME: ____________________ SPOUSE: ____________________
ADDRESS: ____
PHONE NUMBER: ____________________ SSN: ____________________
PATIENT ACCOUNT NUMBER: ____________________

FAMILY STATUS: List all dependents that you support

NAME	AGE	RELATIONSHIP

EMPLOYMENT AND OCCUPATION

Employer: ____________________ Position: ____________________
Contact Person & Telephone Number: ____________________
If Self-Employed, 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 (if Self-Employed)		
Add	Other Income:		
	Interest & Dividends		
	From Real Estate		
	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 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 may be required to provide proof of the information I am providing.

____________________ ____________________ ______
Signature of Patient or Guarantor   Signature of Spouse   Date