WATSONVILLE
COMMUNITY HOSPITAL

Instructions for the Charity Application

The following information and supporting documents must be provided to evaluate this application for a possible reduction of hospital expenses provided by Watsonville Community Hospital.

Please complete all section of the application and provide applicable documents. Return the application to the Admitting Department or to the Business Office at the address below:

Attn: Financial Counselors
75 Nielson St
Watsonville, CA. 95076

Should you need assistance or have any questions regarding the Charity Application, please call 831-761-5689 or 831-761-5690.

List of documents required to complete the Charity Application:

- Copy of ID and Social Security Card
- Homeless Affidavit

Proof of Gross Income

- Check Stubs (last 3 Months)
- Employers Statement
- W-2 Form
- Complete Tax Return
- Profit/loss Statement from accountant (if self-employed)
- Bank Statements (3 months, all pages, for all accounts)
- Unemployment Benefits/EDD (3 months paystubs)
- Social Security/Disability
- Worker's Compensation
- Strike Benefits
- Welfare/AFDC/General Relief
- Veteran's Benefits
- Stipends
- Alimony
- Child Support
- Military Family Allotments
- Private or Government Pensions
- Proceeds from Insurance or Annuity Payments
- Income from Dividends
- Interest Income
- Rental Income
- Royalties
- Farm Income
- Other Assets

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Charity Care and Low-Income Financial Assistance Application

To be completed by financially responsible party. Please complete this application in its entirety.

Date: _____

Patient Information

Patient's Name: _____ Patient's Employer: _____

Spouse's Name: _____ Spouse's Employer: _____

Patient's Address: _____

City: _____ State: _____ ZIP: _____

Patient's Phone #: _____

Patient's Date of Birth: _____ Spouse's Date of Birth: _____

Social Security Number: _____Spouse's Social Security Number: _____

Guarantor Information

Guarantor's Name: _____ Guarantor's Employer: _____

Guarantor's Address: _____

City: _____ State: _____ ZIP: _____

Patient's Phone #: _____ Guarantor's Social Security Number: _____

Please fill out the following:	Total for past 12 months	
	Patient	Spouse
Wages	$ _____	$ _____
Social Security	$ _____	$ _____
Strike Benefits	$ _____	$ _____
Alimony or Child Support	$ _____	$ _____
Military Allotment	$ _____	$ _____

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Dividends/Interest	$ _____	$ _____
Pensions	$ _____	$ _____
Unemployment	$ _____	$ _____
Disability	$ _____	$ _____
IRA	$ _____	$ _____
Trust Account	$ _____	$ _____
Interest Income	$ _____	$ _____
Other	$ _____	$ _____

Check the appropriate boxes below as you compile to submit:

Proof of Income for Patient & Spouse ( )

Pay Check Stubs for Patient & Spouse ( )

Current W-2 Form ( )

All Pages of Tax Return for Previous Year ( )

Expenses:

Submit last month's expense receipts

House / Rent Payment: $ _____ Food: $ _____ Insurance: $ _____

Gas & Electricity: $ _____ Water: $ _____ Trash: $ _____

Child Support: $ _____ Auto Expenses: $ _____

Credit Cards:

Submit last statements

Company: _____

Balance Owing: $_____ Amount Available: $_____

Company: _____

Balance Owing: $ _____ Amount Available: $_____

Company: _____

Balance Owing: $ _____ Amount Available: $_____

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Medical Bills: ***Submit last statement***

Hospital: _____ Doctor Names _____

Amount Owed $ _____

Number of dependents in my household: _____

Name: _____ Relationship: _____ Age: ____

Name: _____ Relationship: _____ Age: ____

Name: _____ Relationship: _____ Age: ____

Name: _____ Relationship: _____ Age: ____

Name: _____ Relationship: _____ Age: ____

Name: _____ Relationship: _____ Age: ____

Bank References: ***Submit all pages of past 3 statements***

Checking: Bank Name: _____ Account# _____

Savings: Bank Name: _____ Account# _____

Assets:

Do you own your own Home?	Yes ( ) or No ( )	Value: $ _____
Is your home a Duplex / Triplex?	Yes ( ) or No ( )	
Do you own other Property?	Yes ( ) or No ( )	Value: $ _____
How many automobiles do you own? __	Yes ( ) or No ( )	Value: $ _____

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STATEMENT

I certify the information provided is true and accurate to the best of my knowledge. Further, I have or will apply for any assistance (Medical, Medicare, insurance, etc.) that may be available for payment of medical services, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for medical services.

I understand this application is for the hospital to evaluate eligibility for Charity Services. I also understand the hospital will verify the information, which may include obtaining a credit report. If the information I have given proves to be untrue, or if I fail to comply with the referral process for Medical, Medicare, California Children's Services, or other identified programs this will result in forfeiture of the right to be considered for Charity Care.

I affirm the statements made herein are true and correct to the best of my knowledge.

Signature of the applicant: _____ Date: _____

Witness: _____ Date: _____

HOMELESS AFFIDAVIT

I, _____, I hereby certify I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others and or General Relief.

I also acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in denial of this application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services may be considered an unlawful act. I also acknowledge and consent that a credit report may be obtained, or other such measure may be taken to verify the information provided herein. I fully understand that Watsonville Community Hospital Charity Care program is a "Payer of Last Resort" and herby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits that may become payable, for fitness or injury, for which Watsonville Community Hospital provided care.

_____ _____

Patient/Guarantor Signature Date