Subject:	DISCOUNT PAYMENT POLICY AND CHARITY CARE POLICY APPLICATION	Formulated:	09/93
Governing Board Approval – Date:		Revised:	02/04, 03/08, 04/10, 08/17

Application for Discount Payment Policy and Charity Care

To be completed by Financial Responsible Party
Please complete this application in its entirety

Date: _____ Account Number: _____

Applicants Name	
Patient Name	
Patients Employer	
Patients Address	Street: City/State/Zip Code:
Patients Phone Number	
Patients Date of Birth	
Patients Social Security Number or Individual Taxpayer Identification Number	

Guarantor Name (may be self)	
Guarantor Employer	
Guarantor Address	Street: City/State/Zip Code:
Guarantor Phone Number	
Guarantor Date of Birth	
Guarantor Social Security Number or Individual Taxpayer Identification Number	

As provided for in Federal Law, I hereby request that VENTURA COUNTY HEALTH CARE AGENCY make a determination of my eligibility for uncompensated services. I understand that the information that I submit concerning my annual income and family size is subject to verification by the Agency. I also understand that if the information is determined to be false, such determination will result in a denial of providing services as uncompensated services, and that I will be liable for charges for services provided.

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Please fill out the following Forms of Income:	Monthly	Total for last 12 months
Wages:		$_____
Other Related to Work: Strike Benefits Unemployment Military Allotment		$_____
Retirement Related Income: Social Security Pensions IRA		$_____
Other: Alimony/Child Support Dividends/Interest Disability Trust Account Interest Income Other		$_____

Proof of income attached: { } W-2 Form { } Pay check stubs { } Tax Return

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Expenses (Essential Living Expenses):

Essential Living Item	Monthly Amount
Rent or Mortgage (including maintenance expenses)	$
Food and Household Supplies	$
Utilities (Water, Gas, Electricity, Trash) and telephone (cell and land line)	$
Clothing	$
Medical and Dental Payments	$
Insurance	$
School and Child Care	$
Child and Spousal Support	$
Transportation and Automobile Expenses (including insurance, fuel, and repairs)	$
Installment Payments	$
Laundry and Cleaning Expenses	$
Other Extraordinary Expenses	$

Credit Cards:

Credit Card Company	Paid Each Month	Amount Available
	$	$
	$	$
	$	$
	$	$

Medical Bills:

Hospital/Doctor Names	Amount
	$
	$
	$
	$

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List family members in household:

Name	Relationship

Bank References:

Checking: Name/Branch:_____Account # _____

Savings: Name/Branch_____Account # _____

I agree that my physician may be informed of the status of this application for uncompensated care.

I understand that I may be asked to prove my statements and that my eligibility statement will be subject to verification by contact with my employer, bank, credit verification and property searches.

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

Signature of applicant: _____**Date:**_____

Witness:_____**Date:**_____