PIH HEALTH

1225 Wilshire Blvd.
Los Angeles, CA 90017

P: 213.977.2121
TDD: 213.977.2580

PIH HEALTH HOSPITAL
REQUEST FOR
FINANCIAL ASSISTANCE/
UNCOMPENSATED SERVICES

ACT: MR:

DOB:
ADM: RM:

Completed applications may be submitted via mail to:
PIH Health Good Samaritan Hospital
Attn: Patient Financial Services – FAP Unit
1225 Wilshire Boulevard, Los Angles, Ca 90017-2395

I ask PIH Health to determine if I am eligible for help in paying for my hospital bill. I understand that I need to give certain information for this to be done. I understand that filling out this form does not guarantee that I will receive this help. If I am not eligible for uncompensated services, I am responsible for my hospital bill.

Name _____ Account Number _____

Address _____ Phone Number _____
Street City State Zip

Employer Name _____ Employer Phone # _____

Employer Address _____

Date of Birth _____ Sex Code ____ 1=Male 2=Female Number of Family Members Living with You ____

Name	Relationship	Age	Gender	Name	Relationship	Age	Gender

Physician Name _____ Diagnosis _____

INCOME **PLEASE PROVIDE PHOTOCOPIES OF CHECKS AND BANK STATEMENTS, AND LIST INCOME**

	Monthly	Annual		Monthly	Annual
Wages (Self)			Unemployment Compensation		
(Spouse)			Strike Benefits		
(Other Family Member)			Alimony/Child Support		
Farm or Self Employment			Military Family Allotments		
Public Assistance			Pensions		
Social Security			Income (Dividends, Interest, Rent)		

EXPENSES (Monthly)

Mortgage/Rent	_____ (1)	Medical Insurance	_____
Utilities	_____	Auto Insurance	_____
Telephone	_____	Medical Bills	_____
Food	_____	Hospital	_____
Finance/Other Loans	_____	Physician	_____
Auto Loans	_____	Medication	_____

(1) If none, source of housing _____ **TOTAL EXPENSES** _____

Do you own a home? ☐ Yes ☐ No If yes, estimated value _____ Amount owed _____

Do you own other property? ☐ Yes ☐ No If yes, estimated value _____

Do you own automobiles? ☐ Yes ☐ No If yes, Model/Make _____ Year ____ Value _____

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I agree to tell the provider of services, within 10 days, if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses, or in the persons in the household or of any change of addresses.
- I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with my employer, bank, credit verification and property searches.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county or hospital from proceeds of any litigation or settlement resulting from such act.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the services rendered by PIH Health or I may appeal decision in writing with additional documentation.

_____ _____ _____ _____
Signature Date Time Print Name

Not Part of the Permanent Medical Record **Return to Business Office**