Martin Luther King Jr. Community Hospital
Financial Assistance Application

Patient Name | Patient Account Number

Telephone Number | Social Security Number | Birth Date (Month/Date/Year)

☐ Employed
☐ Unemployed

Employer (Name, Address and Telephone Number)

Spouse Name | Social Security Number | Birth Date (Month/Date/Year)

A. *Income:* Please provide the income for each of the following persons in your household.

		Circle One			**Circle One**
Patient	$______________	/Hr /Wk /Month /Year	Patient's Father (if patient is a minor)	$_____________	/Hr /Wk /Month /Year
Spouse	$______________	/Hr /Wk /Month /Year	Patient's Mother (if patient is a minor)	$_____________	/Hr /Wk /Month /Year

Total Yearly Family Income: $_______________

B. *Family Members:* Please provide the number of persons (number of dependents listed on tax return).. ___________________

C. *Income Verification:* Please provide the following types of documentation to verify your income.

- IRS Form W-2
- Paycheck Remittance
- Tax Return
- Bank Statements
- Employer Verification
- Unemployment Compensation Determination Letters
- Proof of Participation in a Government Assistance Program other than AFDC, Medical, CCS and food stamps
- Social Security or Workers' Compensation Determination Letters
- RSDI letter
- Other, Please Describe:
  ____
  ____
  ____
- If you are unable to provide one of the sources of income documentation listed in Section C, please explain why this information is not available:
  ____
  ____
  ____
  ____

D. *Residency*:

Give your household's county and state of residence (where you make your permanent home) or where you intend to reside if you do not have a permanent home:

County: ________________ State: __________________

Please check all of the following that apply to you.

_____ Not a current resident of Los Angeles County
_____ Minor student whose parents primarily support you and who live outside of Los Angeles County
_____ Inmate or resident of a institution operated by a state or federal agency
_____ Inmate or resident of a state school
_____ Moved to Los Angeles County solely to obtain healthcare assistance

Proof of residency or intent to reside includes two of the following: mail addressed to you, your spouse or children; voting records; automobile registration; driver's license or other official identification; school enrollment records; property tax receipts; or rent, mortgage payment, and utility receipts.

I understand that Martin Luther King Community Hospital (MLKCH) may verify the financial information contained in this Financial Assistance Application ("Application") in connection with MLKCH evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize MLKCH to request reports from credit reporting agencies and the Social Security Administration. I am aware that falsification of information on this Application may result in denial of entitlement to financial assistance.

____ Date____________________________
Signature of Patient or Responsible Party

____ Date____________________________
Hospital Employee Signature if any part of Financial Assistance Application Completed by a Hospital Employee

Policy Ref # (Date Created)