

CITY OF HOPE CHARITY  
CARE FINANCIAL EVALUATION FORM

Instructions

As part of our commitment to serve the community, City of Hope elects to provide financial assistance to patients who are indigent and satisfy certain requirements.

Financial assistance is not considered to be a substitute for personal responsibility, and patient families are expected to cooperate by providing complete and accurate information so City of Hope can determine a patient's eligibility for our financial assistance program, and to contribute to the cost of the patient's care based on individual ability to pay.

Individuals who are eligible to apply for public assistance, as well as individuals with the capacity to purchase health insurance, will be encouraged to do so as a means of assuring access to health care services.

To determine if a patient qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please provide the following information and copies of supporting documentation with your Charity Care Financial Evaluation Form:

- IRS Form W-2 and Earnings Statement of all household earnings
- Last two paycheck stubs for \_\_\_\_\_
- Most current bank statement(s)
- Income tax return for previous tax year
- Governmental assistance, Social Security or Workers Compensation Eligibility
- Unemployment or Disability compensation letter
- Alimony or support payments received
- Proof of U.S. Residency (U.S. Passport, Green Card/Visa, Driver's License, Social Security Card, etc.).
- Notarized letter indicating family member/friend supporting patient

In the event income verification is unavailable, please contact our office for further instructions.

**Applications without income verification are considered incomplete and will not be processed.**

<b>Patient Name</b>	_____	<b>Spouse Name</b>	_____
<b>Address</b>	_____		
		<b>Phone</b>	_____
<b>Patient Social Security #</b>	_____		<b>Spouse Social Security #</b>

For assistance completing the Charity Care Financial Evaluation Form, please contact a financial counselor at:

1500 E. Duarte Road, Duarte CA, 91010 or call: 626-218-9201 or \_\_\_\_\_

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**A: Family Status (List all dependents that you support)**

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

**Total Family Size:** \_\_\_\_\_

	Patient	Spouse
<b>Employer</b>		
<b>Position</b>		
<b>Contact Person</b>		
<b>Contact Phone</b>		
<b>If Self Employed, Name of Business</b>		

	Guarantor	Spouse
<b>C: Current Monthly Income</b>		
1. Gross Pay from Employment		
2. Income from operating business (self-employed)		
3. Other Income		
a. Interest and dividends		
b. From real estate or rental property		
c. Social Security		
d. Unemployment		
e. Disability		
f. Alimony or support payments received		
<b>TOTAL (Please Add)</b>		

	Guarantor	Spouse
<b>D: Deductions</b>		
1. Alimony, support payments paid		

	Guarantor	Spouse
<b>E: Total Monthly Income</b>		
Total in box C less total in box D		

By signing this form, I/we agree to allow COHNMC to check employment and credit history for the purpose of determining my eligibility for charity care.

I/we affirm that all statements on this application are true to the best of my knowledge and belief.

Signature of Patient or Guarantor	Date
Signature of Spouse/Domestic Partner	Date

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CHARITY CARE EVALUATION FORM

Asset Declaration Form  
City of Hope Charity Care Assistance Program

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

MRN: \_\_\_\_\_

Please list value of all assets excluding primary residence and vehicle(s) used for daily living (i.e., work, school, Dr. appointments). Do not include amounts held in patient retirement or deferred compensation plans such as 401k, IRA's, etc.

	Present Value	Held as owner or beneficiary	Held jointly or severally w/ another person % shared	If not held in owner's name, state whose name and relationship to member	How acquired? (Purchase, lease, gift, inheritance)
<b>Property:</b>					
Real Estate					
Lands					
<b>Moveable Property:</b>					
Vehicles other than primary					
Motorcycle					
Jewelry					
Recreational Vehicles					
<b>Other Investments</b>					
Investment in banks					
Investment in stock markets					
Investment in companies					
Insurance Policies					
<b>Total:</b>					

I/we affirm that all statements on this form are true to the best of my knowledge and belief:

\_\_\_\_\_  
Signature of Patient or Guarantor Date

\_\_\_\_\_  
Signature of Spouse/Domestic Partner Date