CHARITY APPLICATION

Application should be returned within 30 days of receipt. When submitting your application, please provide the following information:
(1) Most recent paycheck stub copy, (2) Current month's bank statement, (3) Most recently filed tax return and W2 copy.
Please contact our Customer Service Department at (866) 823-4250 with any questions or concerns.
Patient Account Number and Admit Date are available on attached letter correspondence.
A soft credit pull will be accessed and this will not affect your credit score.

Patient Acct Number: _____ Admit/Reg Date: _____ Hospital Visited: _____

I. Patient Information (if patient is same as responsible party skip to section two).

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____ Marital Status: _____ Social Security# _____

Address: _____ City: _____ State: _____ Zip: _____

How many yrs address: ____ Home# _____ Cell# _____

Are you a U.S. Citizen? ◯ Yes ◯ No Birth Place: _____ Drivers License# _____

II. Responsible Party

Last Name: _____ First Name: _____ Middle Initial: _____

Spouse Last Name: _____ Spouse First Name: _____ Middle Initial: _____

Date of Birth: _____ Marital Status: _____ Social Security# _____

Address: _____ City: _____ State: _____ Zip: _____

How many yrs address: ____ Home# _____ Cell# _____ Relationship to Pt: _____

Are you a U.S. Citizen? ◯ Yes ◯ No Birth Place: _____ Drivers License# _____

II. Responsible Party Employer Information

Employer's Name: _____ Employer's Address: _____

City: _____ State: _____ Zip: _____ Position/Title: _____

Phone: _____ Years employed: ____ Mthly Hrs (Reg/OT): ____ Hourly Rate: _____ Pay Frequency _____

III. Spouse Employer Information

Employer's Name: _____ Employer's Address: _____

City: _____ State: _____ Zip: _____ Position/Title: _____

Phone: _____ Years employed: ____ Mthly Hrs (Reg/OT): ____ Hourly Rate: _____ Pay Frequency _____

IV. Household Information (all persons in household including self)

Name	DOB	Relationship to Responsible Party

V. Insurance information

Insurance Name: _____ Policy # _____ Group # _____ Employment Related? _____

Insurance Address: _____ City: _____ State: _____

Name Policy Holder: _____ Beginning Coverage Date: _____ Person Covered: _____

VI. Miscellaneous Income Per Month

Dividends, Interest $ _____ Pensions $ _____ Public Assistance/Food Stamps $ _____

Social Security $ _____ Investment/Rental Income $ _____ Grants $ _____

Unemployment/Workers Compensation $ _____ Child Support/Alimony $ _____ Other $ _____

VII. Miscellaneous Expenses

Do you own or rent Housing? _____ Market Value of Home $ _____ Years Left on Home Loan: _____

Outstanding Balance on Home Loan $ _____ Outstanding Balance on Auto Loan$ _____

Years Left on Auto Loan: _____ Outstanding Balance on Medical Bills $ _____

VIII. List Monthly Expenses for following:

Rent/Mortgage $ _____ Insurance (Homeowners/Medical/Life/Auto/Other) $ _____

Food/Clothing $ _____ Electric/Water/Gasoline $ _____ Loans $ _____

Property Tax $ _____ Telephone/Cellular Phone $ _____ Car Payments $ _____

Medical Bills/Medications $ _____ Credit Cards $ _____ Alimony/Child Support $ _____

Other $ _____ **Total Monthly Miscellaneous Expenses $** _____

IX. Monthly Net Income

Responsible Party's Monthly Income $ _____ Spouse's Monthly Income (If Applicable) $ _____

Total Monthly Miscellaneous Income $ _____ Total Monthly Miscellaneous Expenses $ _____

Total Mthly Income$ _____ **Total Mthly Expenses $** _____ **Net Income (less) Net Expenses =** _____

X. Assets/Equity - List Dollar Value for the following:

Bank Name	Bank Address	Account #	Balance	Account type
				Checking
				Checking
				Savings
				Savings

CDs/Investments/IRA(s) $ _____ Home Value $ _____ Trust Funds $ _____

Other Real Estate $ _____ Life Insurance $ _____ Other Assets $ _____

Motor home(s)/Boat $ _____ Cash Value $ _____ Motorcycle $ _____ Cash Value $ _____

Automobile(s) $ _____ Make/Model: _____ Cash Value $ _____

Total Equities $ _____

XI. Third Party Liability

Is treatment related to a Third Party Liability Claim? ◯ Yes ◯ No

If yes; do you have an attorney? ◯ Yes ◯ No

Attorney Name: _____

Attorney Address: _____

City: _____ State: _____ Zip: _____

AttornyPhone: _____

XI. Comments

_____

_____

_____

_____

_____

_____

_____

_____

Please contact our Customer Service Department at (866) 823-4250 with any questions or concerns in completing the form.

I certify that the information above is accurate and complete to the best of my knowledge.

Applicant Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Hospital Representative Signature: _____ Date: _____

Please return application and all required documents to:

UHS Western Region CBO
Customer Service
2700 Fire Mesa Street
Las Vegas, NV 89128

Phone: (866) 823-4250
Fax: (702) 360-5071

E-mail: WesternCBOCharity@uhsinc.com