BHC Alhambra Hospital

Visiting Hours
Youth Services Mon-Sun 05:30 pm – 06:30 pm
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4619 N. Rosemead Blvd.
Rosemead, CA 91770
www.bhcalhambra.com
Tel: (626) 286-1191

(Administration Use Only)

Patient#_____

Admit Date:_____

Date Completed:_____

Approval:_____

Financial Disclosure Form

THIS FORM IS TO BE COMPLETED BY PERSON RESPONSIBLE FOR THE BILL

The information requested is to allow us to assist you in establishing a reasonable payment program. This information is confidential.

PATIENT:

1. Name:_____ SSN:_____
   Last First Middle
2. Address:_____
   Street
   _____
   City State Zip Code
3. Employment:_____
   Employer Phone Number
4. Are you disabled? Yes / No If yes, please describe:_____
   _____

RESPONSIBLE PARTY:

5. Name:_____ SSN:_____
   Last First Middle
6. Address:_____
   Street
   _____
   City State Zip Code
4. Employment:_____
   Employer Phone Number
5. Are you disabled? Yes / No If yes, please describe:_____
   _____

DEPENDENTS OF RESPONSIBLE PARTY (SPOUSE/DOMESTIC PARTNER):

9. Name:_____ SSN:_____
Last First Middle

10. Address:_____
Street

_____
City State Zip Code

11. Employment:_____
Employer Phone Number

12. Are you disabled? Yes / No If yes, please describe:_____

_____

_____

DEPENDENTS OTHER THAN SPOUSE/DOMESTIC PARTNER FOR WHICH YOU PROVIDE FOOD AND SHELTER:

13. Ages:_____

14. Are any of the above dependents employed? Yes / No If yes, where?_____

_____

15. Are any of the above dependents disabled? Yes / No Disability:_____

_____

16. Which of the above dependents do not live with you?_____

17. Why?_____

_____

INSURANCE:

18. Is the above patient covered by any health insurance through an employer or private plan?
Yes / No
If yes, name of the primary insurance:_____
Benefits Covered:_____
Name of the secondary insurance:_____
Benefits Covered:_____

_____

RESPONSIBLE PARTYS' FINANCIAL INFORMATION

1.1 Present Employer(s) All Sources, Occupations, Work Phone, Monthly Gross Pay, Monthly Take Home, Years on the Job

(a)_____

(b)_____

(c)_____

(d)_____

_____

1.2 Any other source of income:_____ Monthly Amount_____

_____ Total Monthly Income:_____

PLEASE LIST AVAILABLE ASSETS:

CARS	$_____	CHECKING	$_____
HOMES	$_____	STOCKS/BONDS	$_____
SAVINGS	$_____	LIFE INSURANCE	$_____
OTHER	$_____	REAL ESTATE	$_____

19.

Monthly Expenses	Monthly Payments	Balance	Comments / Purpose
Food	$	$	
Gas / Heat	$	$	
Electric	$	$	
Water	$	$	
Telephone	$	$	
Transportation / Gas	$	$	
Rent / Mortgage	$	$	
2nd Mortgage	$	$	
Alimony	$	$	
Child Support	$	$	
Auto 1	$	$	
Auto 2	$	$	
Car Insurance	$	$	
Life Insurance	$	$	
Health Insurance	$	$	
Credit 1	$	$	
Credit 2	$	$	
Credit 3	$	$	
Bank Loan 1	$	$	
Bank Loan 2	$	$	
Finance Co. 1	$	$	
Finance Co. 2	$	$	
Other	$	$	
Other	$	$	

20. Total Monthly Expenses $_____

Please list any other financial conditions that should be considered in establishing a payment plan:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

In order to receive free or discounted healthcare, you must cooperate fully with our need for accurate and detailed financial information, including the timely production of necessary documentation to support this application for financial need. Completion of this application does not guarantee that you will be eligible to receive free or discounted healthcare.

I hereby authorize representatives of BHC Alhambra Hospital, its affiliates, and their respective agents and employees to make whatever inquiries necessary to verify the information furnished on this form or to release any information regarding this treatment and/or hospitalization to any insurance company or a third party to seek settlement of this account. I hereby state that to the best of my knowledge the information given above is true and complete. I agree to authorize BHC Alhambra Hospital of any material changes in my financial situation. I further authorize BHC Alhambra Hospital, its affiliates, and their respective agents and employees to review and/or inquire into my credit history using any means available to obtain a current Credit Bureau History Report.

Date:_____ Signature:_____

Witness:_____ Spouse/Domestic Partner:_____

For additional information or questions, you may contact:_____