Application for Hospital Financial Assistance/Charity Care

MPTF offers financial assistance for your hospital bill to qualified patients receiving medically necessary care in our Samuel Goldwyn, Jr. Center for Behavioral Health (CBH).

Patient Information	
Patient Name:	Patient Account #:
Phone Number:	Birth Date:
Street Address: City: State: Zip Code:	Social Security #: Marital Status:

Family Household Information		
Family Size: Include patient, spouse, domestic partner, dependents		
Family Income (monthly) Remember: You must include proof of income with your application. Submit tax return, or pay stubs, or written documentation from all income sources.		
Name on Check	Issued By	Issued Amount
		$
		$
		$
		$
If you have more details about your current financial situation, please add them on a separate page and include it with this form.		
Annual out-of-pocket healthcare cost: Total copays, coinsurances, deductibles, or deposits within the 12 months period for medically necessary services.		$

I hereby acknowledge that the above information is true and correct to the best of my knowledge. I understand that providing false information will disqualify me for financial assistance. I hereby authorize MPTF to communicate with responsible relatives, to secure information regarding income, to contact financial institutions for financial data, and to contact any other agency or persons regarding my financial status.
I further agree to notify MPTF of any change in my financial situation.

Signature of Applicant _____ Date _____

For Questions call (818) 876-1076. Return Completed Form to:
MPTF 23388 Mulholland Drive, Woodland Hills, CA 91364 Attn: PBS Manager Mailstop 70