

**COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES
PUBLIC-PRIVATE PARTNERSHIP (PPP) AND HEALTHY WAY LA (HWLA) PROGRAMS
CERTIFICATION OF INDIGENCY**

(To be Completed by Interviewer)

SECTION A. PATIENT INFORMATION

Patient Name: _____

*Patient Address: _____

Medical Record # _____ Acct. # _____ Visit Date: _____

** Required to satisfy County residency policy. If homeless, Affidavit of Residency is required.*

SECTION B. HOUSEHOLD/INCOME INFORMATION

Total Number of Family Members Living in the Home: _____

Total Net Family Income: _____

PPP Program Patient is Indigent: Yes No

(Net family monthly income means the income received by the patient's household members less taxes.)

Total Gross Family Income: _____

HWLA Program Patient is Indigent: Yes No

(Gross family monthly income means total income including mandatory deductions (e.g., State and Federal taxes FICS, DSI, mandatory union/retirement). Do not include voluntary deductions (e.g., credit union deductions, health insurance, life insurance, voluntary union dues, 401K, etc). Please refer to HWLA Income Calculation Worksheet.

SECTION C. PATIENT CERTIFICATION

I certify that, as of today's date, I, (or patient), do/(does) not have Medi-Cal, Medicare, or private health insurance. During the next twelve (12) months, if a change in my health care coverage, family size, or family income later occurs, I promise to immediately report that fact to my Public-Private Partnership (PPP) provider.

I further certify and declare under penalty of perjury under the laws of the State of California that the information I have provided is true and complete. I understand that a random number of patients will be asked later for proof of some or all of the information used for this certification and that a credit check may be done. I understand that I am expected to save documents I might have that would help prove that what I said today is true, (for example, copies of pay stubs, income tax returns, bank statements, property statements, receipts, etc.), for 12 months from the date of this certification. If I am asked for these documents in the next 12 months, I will have 20 days to mail or bring the information to the facility or to give some other acceptable verification. If I am asked for this proof and don't provide it, I may be held responsible for the full charges for my medical care.

Patient/Responsible Relative Signature: _____ Date: _____

SECTION D. COUNTY/PARTNER CERTIFICATION

County/Partner Interviewer: _____ Date: _____

Effective February 1, 2010