EXHIBIT B - #53.04

UNINSURED PATIENTS POLICY APPLICATION

Account #'s____ **Date:____________________**

Section One: Personal Information:

1.Patient Name:____________________________2.Social Security #___________________________

3.Street Address: ___________________________City, State, Zip:_____________________________

4.Guarantor: ______________________________5.Acct#____________Service Date:______________

6.Phone# (home)___________________(work)__________________(cell)______________________

7:Total Income:_________________ 8. Family Size:_____________

Section Two: Income Criteria

Sources of Income: ____________________

Gross Salary/Wages: _______________

In connection with your application to participate for The Uninsured Discount, The Valley Hospital may require some additional information to be supplied by you. This information may be necessary to complete your application.

Documents Required: Identification (i.e. Drivers license, SS card, birth certificate), Current Pay Stubs, Previous Completed Income Tax Return, or Income noted above.

Please sign the bottom of this form and return it with the documentation required.

____ ________________

Signature Date