



**Emergency
Trauma
Fund**

TRAUMA CENTER APPLICATION FORM
 Emergency Trauma Fund
 Administered by MercyCare, Inc.
 2772 Gateway Road, Carlsbad, California 92009
 Ph: (888) 776-3729 Fx: (800) 498-7077

ETF / MERCYCARE USE ONLY
 DATE RECEIVED STAMP

1. NAME OF HOSPITAL	2. FEDERAL TAX ID NUMBER
3. STREET ADDRESS	4. MAILING ADDRESS (IF DIFFERENT)
CITY, STATE & ZIP CODE	CITY, STATE & ZIP CODE
5. CONTACT NAME & TITLE	6. PHONE NUMBER
7. EMAIL ADDRESS	8. FAX NUMBER

9. DESIGNATE HOSPITAL STATUS (MARK ALL THAT APPLY)

PRIVATE NOT FOR PROFIT
 PRIVATE FOR PROFIT
 COUNTY / CITY GOVERNMENT
 STATE AGENCY
 SPECIAL DISTRICT
 OTHER:

10. THE JOINT COMMISSION (TJC) ACCREDITED <input type="checkbox"/> YES <input type="checkbox"/> NO	11. IF ACCREDITED BY OTHER THAN TJC, PLEASE NOTE ACCREDITING COMPANY:		
11. DOES YOUR HOSPITAL RECEIVE DISPROPORTIONATE SHARE HOSPITAL (DSH) FUNDING <input type="checkbox"/> YES <input type="checkbox"/> NO	12. LICENSED TRAUMA CENTER <input type="checkbox"/> YES <input type="checkbox"/> NO	13. IF YES, WHAT LEVEL <input type="checkbox"/> LEVEL I <input type="checkbox"/> LEVEL II <input type="checkbox"/> LEVEL III	
14. NUMBER OF TRAUMA PATIENTS CARED FOR PREVIOUS FISCAL YEAR	15. TOTAL NUMBER OF EMERGENCY PATIENTS CARED FOR PREVIOUS FISCAL YEAR	16. PERCENTAGE THAT WERE MEDICARE PREVIOUS FISCAL YEAR %	17. PERCENTAGE THAT WERE MEDICAID OR MEDI-CAL PREVIOUS FISCAL YEAR %
18. AMOUNT OF CHARITABLE CARE PROVIDED BY HOSPITAL PREVIOUS FISCAL YEAR \$	19. DISCOUNT TO THE UNINSURED / UNDERINSURED / SELF-PAY PREVIOUS FISCAL YEAR \$		

19. STATEMENT OF NEED - IN THE SPACE BELOW, PLEASE WRITE A BRIEF STATEMENT DESCRIBING NEED FOR ADDITIONAL EMS / TRAUMA FUNDING

I, THE UNDERSIGNED, DO HEREBY ATTEST THAT THE INFORMATION CONTAINED WITHIN THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MY APPLICATION WILL BE DISQUALIFIED SHOULD FALSIFIED INFORMATION BE REVEALED.

PRINTED NAME	TITLE
SIGNATURE	DATE