Kindred Hospitals

Admission Notice &
Charity Care/Financial Assistance Application Form

California requires all hospitals to provide free or reduced-price care to people and families who meet certain income requirements. You or your family member may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance.

Helpful Terms:

- "Charity Care" refers to the scenario where a patient or guarantor has no financial responsibility.
- "Financial Assistance" refers to the scenario where a patient or guarantor has some financial responsibility but at a discounted rate (*i.e.*, a discount payment).

Charity Care and Financial Assistance are secondary to all other financial resources available to the patient, including the following (collectively, "Third-Party Coverage"):

- Group or individual Medical Plans
- Workers' Compensation
- Medicare/Medi-Cal
- Other State, Federal, or Military programs

In those situations where payment sources are not available, for medically necessary hospital care received on or after Jan 1, 2022, Kindred Hospital will consider patients for Financial Assistance and Charity Care when Third-Party Coverage, if any, has been exhausted, based on the following criteria:

Income as a Percentage of Federal Poverty Level	Percentage Discount	Category
Less than or equal to 200 percent	One Hundred Percent (100%)	Charity Care
201-300 percent	Seventy-five percent (75%)	Financial Assistance
301-400 percent	Fifty percent (50%)	Financial Assistance

For patients who are eligible for Financial Assistance, in no event will such a patient's or guarantor's responsibility exceed the amount Kindred Hospital would expect in good faith to receive from Medicare or Medi-Cal, whichever is greater, for providing such services. Such patients are also entitled to a reasonable payment plan to allow payment of the discounted price over time.

How to Apply

Any patient may apply to receive free or reduced-price care. A patient seeking Charity Care or Financial Assistance must provide supporting documentation specified in the application unless indicated otherwise. The application form is included in the admission packet provided at the beginning of your stay, from our website www.kindredhospitals.com, or upon request at any Kindred Hospital.

For your application to be processed, you must:

- Provide information about your family. Patient's family to include- For persons 18 years of age and older- Spouse, Domestic partner, Dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age- Parent, Caretaker relatives, and other children under 21 years of age of the Parent or Caretaker relative.
- Provide information about your family's gross monthly income (income before taxes and deductions)
- Provide documentation for family income.
- Attach additional information if needed.
- Sign and date the form.
- You do not have to provide a Social Security number to apply for financial assistance. If you do not have a Social Security number, please mark "Not Applicable" or "NA."
- Mail or fax completed application with all documentation to:

  Kindred Hospital San Gabriel Valley
  845 N. Lark Ellen Avenue
  West Covina, CA 91791
  Fax: (626) 967-3809
- To submit the application in person, please contact the on-site Kindred Patient Relations Representative.
- We will notify you of the final determination of eligibility and appeal rights, if applicable, within fourteen calendar days of receiving a complete financial assistance application, including documentation of income.

For additional questions or further assistance completing the application contact the Kindred Hospital Patient Relations Representative at (626) 339-5451. You may obtain help for any reason, including disability or language assistance.

You may obtain a copy of Kindred Hospital's Charity Care and Financial Assistance Policy by contacting the on-site Kindred Hospital Patient Relations Representative, or by going to the following URL: https://www.kindredhospitals.com/docs/default-source/default-document-library/locations/transitional-care-hospitals/patient-policies/ca-financial-assistance-policy--kindred-hospitals_nl.pdf.

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program.

Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

More Help

- **Help Paying Your Bill:** There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.
- Kindred Hospitals will provide or assist patients and loved ones in obtaining interpretation or translation services as necessary and address the needs of those with vision, speech, hearing, and cognitive impairments.

Covered California

You may qualify for a discount on a health plan through Covered California, a free service that connects Californians with brand-name health insurance under the Patient Protection and Affordable Care Act. Visit www.CoveredCA.com for more information.

Shoppable Services

You can find a list of Kindred Hospital's "shoppable services" at the following web page: https://www.kindredhospitals.com/locations/ltac/kindred-hospital-baldwin-park/patient-experience/what-to-expect

The Centers for Medicare & Medicaid Services defines a "shoppable service" as a service that can be scheduled by a healthcare consumer in advance.

ATTENTION: If you need help in your language, please call (626) 339-5451 or visit the Kindred Hospital San Gabriel Valley Patient Relations Representative to obtain more information. The office is open 8 a.m. to 5 p.m. Monday through Friday and located at 845 N. Lark Ellen Avenue, West Covina, CA 91791

Aids and services for people with disabilities, like documents in braille, large print, audio, and other accessible electronic formats are also available. These services are free.

Spanish **ATENCIÓN:** Si necesita ayuda en su idioma, llame al (626)339-5451 o visite al Representante de Relaciones con el Paciente de Kindred San Gabriel Valley para obtener más información. La oficina está abierta de 8:00 a. m. a 5:00 p. m., de lunes a viernes, y se encuentra en 845 N. Lark Ellen Avenue, West Covina CA 91791.

También disponemos de ayudas y servicios para personas con discapacidad, como documentos en braille, letra grande, audio y otros formatos electrónicos accesibles. Estos servicios son gratuitos.

Chinese 注意：如果您需要母語協助，請致電 (626)339-5451 或聯絡 Kindred San Gabriel Valley 患者關係代表以了解更多資訊。診所辦公時間為週一至週五上午 8 點至下午 5 點，地址：845 N. Lark Ellen Avenue, West Covina, CA 91791

我們也為殘障人士提供輔助服務，例如點字、大字印刷本、音訊和其他無障礙電子格式的文件。這些服務均免費。

Vietnamese LƯU Ý: Nếu bạn cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi (626)339-5451 hoặc đến gặp Đại diện quan hệ bệnh nhân Kindred San Gabriel Valley để biết thêm thông tin. Văn phòng mở cửa từ 8 giờ sáng đến 5 giờ chiều từ Thứ Hai đến Thứ Sáu và tọa lạc tại 845 N. Lark Ellen Avenue, West Covina, CA 91791

Các dịch vụ hỗ trợ và dịch vụ dành cho người khuyết tật, như tài liệu chữ nổi, chữ in lớn, âm thanh và các định dạng điện tử có thể truy cập khác cũng có sẵn. Các dịch vụ này miễn phí.

Tagalog PAUNAWA: Kung kailangan mo ng tulong sa iyong wika, mangyaring tumawag sa (626)339-5451 o bisitahin ang Kindred San Gabriel Valley Patient Relations Representative para makakuha ng karagdagang impormasyon. Bukas ang opisina 8 a.m. hanggang 5 p.m. Lunes hanggang Biyernes at matatagpuan sa . 845 N. Lark Ellen Avenue, West Covina, CA 91791

Available din ang mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille, malalaking print, audio at iba pang naa-access na electronic format. Ang mga serbisyong ito ay libre.

Korean 주의: 모국어로 도움이 필요하시면 (626)339-5451으로 전화하시거나 킨드레드 볼드윈 파크 환자 관계 담당자를 방문하여 자세한 정보를 얻으십시오. 본 사무실은 월요일부터 금요일까지 오전 8시부터 오후 5시까지 운영하며, 주소는 캘리포니아주 볼드윈 파크 프랜시스퀴토 애비뉴845 N. Lark Ellen Avenue, West Covina, CA 91791

장애인을 위한 점자, 큰 활자체, 오디오 및 기타 접근 가능한 전자 문서 등 다양한 지원 및 서비스도 이용하실 수 있습니다. 이러한 서비스는 무료입니다.

Armenian ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե ձեզ օգնություն է անհրաժեշտ ձեր լեզվով, խնդրում ենք զանգահարել (626)339-5451 հեռախոսահամարով կամ այցելել Kindred San Gabriel Valley-ի հիվանդների հետ կապերի ներկայացուցչին՝ լրացուցիչ տեղեկություններ ստանալու համար: Գրասենյակը բաց է երկուշաբթիից ուրբաթ, ժամը 8:00-ից մինչև 17:00-ն և գտնվում է հետևյալ հասցեով՝ 845 N. Lark Ellen Avenue, West Covina, CA 91791.

Հասանելի են նաև հաշմանդամություն ունեցող անձանց համար նախատեսված օժանդակ միջոցներ և ծառայություններ, ինչպիսիք են Բրայլի գրերով փաստաթղթերը, խոշոր տառերով գրված փաստաթղթերը, աուդիո և այլ հասանելի էլեկտրոնային ձևաչափերը: Այս ծառայությունները անվճար են:

Persian/Farsi

توجه: اگر به کمک به زبان خود نیاز دارید، لطفاً برای کسب اطلاعات بیشتر با شماره (626)339-5451 تماس بگیرید یا به نماینده روابط بیمار Kindred San Gabriel Valley مراجعه کنید. این دفتر از دوشنبه تا جمعه از ساعت ۸ صبح تا ۵ بعد از ظهر واقع شده است 845 N. Lark Ellen Avenue, West Covina, CA 91791 باز است و در آدرس.

کمک‌ها و خدماتی برای افراد دارای معلولیت، مانند اسناد به خط بریل، چاپ بزرگ، صوتی و سایر قالب‌های الکترونیکی قابل دسترس نیز موجود است. این خدمات رایگان هستند.

Russian ВНИМАНИЕ: Если вам нужна помощь на вашем языке, позвоните по телефону (626)339-5451 или посетите представителя по работе с пациентами Kindred San Gabriel Valley, чтобы получить дополнительную информацию. Офис открыт с 8 утра до 5 вечера с понедельника по пятницу и находится по адресу 845 N. Lark Ellen Avenue, West Covina, CA 91791

Также доступны средства и услуги для людей с ограниченными возможностями, такие как документы на языке Брайля, крупным шрифтом, аудио и другие доступные электронные форматы. Эти услуги бесплатны.

Japanese ご注意：ご希望の言語でサポートが必要な場合は、(626)339-5451までお電話いただくか、Kindred San Gabriel Valleyの患者相談担当者までお問い合わせください。窓口は月曜日から金曜日の午前8時から午後5時まで営業しており、住所は 845 N. Lark Ellen Avenue, West Covina, CA 91791です。

障がいのある方向けの支援サービス（点字、拡大印刷、音声、その他の電子形式での資料など）もご用意しております。これらのサービスは無料です。

Arabic

تنبيه: إذا كنتم بحاجة إلى مساعدة بلغتكم، يُرجى
الاتصال على الرقم (626)339-5451 أو زيارة مكتب ممثل علاقات المرضى في كيندريد بالدوين بارك للحصول على مزيد من المعلومات. المكتب مفتوح من الساعة 8 صباحًا حتى 5 مساءً من الاثنين إلى الجمعة، ويقع في شارع فرانسيسكيتو، بالدوين بارك، كاليفورنيا 91706.

كما تتوفر وسائل مساعدة وخدمات للأشخاص ذوي الإعاقة،
مثل الوثائق بطريقة برايل، والطباعة الكبيرة، والوسائط الصوتية، وغيرها من الصيغ الإلكترونية الميسرة. هذه الخدمات مجانية

Punjabi ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ (626)339-5451 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਵਧੇਰੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ Kindred San Gabriel Valley Patient Relations Representative ਨੂੰ ਮਿਲੋ। ਇਹ ਦਫ਼ਤਰ ਸੋਮਵਾਰ ਤੋਂ ਸ਼ੁੱਕਰਵਾਰ ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 5 ਵਜੇ ਤੱਕ ਖੁੱਲ੍ਹਾ ਰਹਿੰਦਾ ਹੈ ਅਤੇ 845 N. Lark Ellen Avenue, West Covina, CA 91791 'ਤੇ ਸਥਿਤ ਹੈ।

ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੱਡੇ ਪ੍ਰਿੰਟ, ਆਡੀਓ ਅਤੇ ਹੋਰ ਪਹੁੰਚਯੋਗ ਇਲੈਕਟ੍ਰਾਨਿਕ ਫਾਰਮੈਟ ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਹਨ।

Mon-Khmer យកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរស័ព្ទទៅលេខ (626)339-5451 ឬទៅកាន់អ្នកតំណាងទំនាក់ទំនងអ្នកជំងឺ Kindred San Gabriel Valley ដើម្បីទទួលបានព័ត៌មានបន្ថែម។ ការិយាល័យបើកពីម៉ោង ៨ ព្រឹក ដល់ ៥ ល្ងាច។ ថ្ងៃច័ន្ទដល់ថ្ងៃសុក្រ និងមានទីតាំងនៅ 845 N. Lark Ellen Avenue, West Covina, CA 91791។

ជំនួយ និងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារជាអក្សរស្ទាប ការបោះពុម្ពធំ សំឡេង និងទម្រង់អេឡិចត្រូនិកដែលអាចចូលប្រើបានផ្សេងទៀតក៏មានផងដែរ។ សេវាកម្មទាំងនេះមិនគិតថ្លៃទេ។

Hmong CEEB TOOM: Yog tias koj xav tau kev pab ua koj hom lus, thov hu rau (626) 339-5451 lossis mus ntsib Kindred San Gabriel Valley Tus Neeg Sawv Cev Tus Neeg Mob Sib Tham kom tau txais xov xwm ntxiv. Lub chaw ua haujlwm qhib 8 teev sawv ntxov txog 5 teev tsaus ntuj. Hnub Monday txog Friday thiab nyob ntawm 845 N. Lark Ellen Avenue, West Covina, CA 91791.

Cov kev pab thiab cov kev pab cuam rau cov neeg tsis taus, xws li cov ntaub ntawv nyob rau hauv daim ntawv Braille, luam ntawv loj, suab thiab lwm yam khoom siv hluav taws xob siv tau. Cov kev pabcuam no pub dawb.

Hindi ध्यान दें: यदि आपको अपनी भाषा में सहायता की आवश्यकता है, तो कृपया (626)339-5451 पर कॉल करें या अधिक जानकारी प्राप्त करने के लिए किंड्रेड बाल्डविन पार्क रोगी संबंध प्रतिनिधि से मिलें। कार्यालय सोमवार से शुक्रवार सुबह 8 बजे से शाम 5 बजे तक खुला रहता है और 845 N. Lark Ellen Avenue,West Covina, CA 91791

विकलांग लोगों के लिए सहायता और सेवाएँ, जैसे ब्रेल, बड़े प्रिंट, ऑडियो और अन्य सुलभ इलेक्ट्रॉनिक प्रारूपों में दस्तावेज़ भी उपलब्ध हैं। ये सेवाएँ निःशुल्क हैं।

Thai หมายเหตุ: หากคุณต้องการความช่วยเหลือในภาษาของคุณ โปรดโทร (626)339-5451 หรือไปที่ตัวแทนฝ่ายความสัมพันธ์ผู้ป่วยของ Kindred San Gabriel Valley เพื่อรับข้อมูลเพิ่มเติม สำนักงานเปิดทำการตั้งแต่ 8.00 น. ถึง 17.00 น. ตั้งแต่วันจันทร์ถึงวันศุกร์ และตั้งอยู่ที่ 845 N. Lark Ellen Avenue, West Covina, CA 91791

นอกจากนี้ ยังมีบริการช่วยเหลือและบริการสำหรับผู้พิการ เช่น เอกสารอักษรเบรลล์ อักษรตัวใหญ่ เสียง และรูปแบบอิเล็กทรอนิกส์ที่เข้าถึงได้อื่นๆ บริการเหล่านี้ไม่มีค่าใช้จ่าย

Kindred Hospital San Gabriel Valley

Charity Care/Financial Assistance Application Form – confidential

Please fill out all the information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION
Select all that apply: Are you applying for Charity Care (*i.e.*, free care)? □ **Yes** □ **No** Are you applying for Financial Assistance (*i.e.*, reduced-price care)? □ **Yes** □ **No**
Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*
Has the patient applied for Medi-Cal? □ **Yes** □ **No**
Does the patient receive state public services such as EBT-SNAP, or WIC? □ **Yes** □ **No**
Is the patient currently homeless? □ **Yes** □ **No**
Is the patient's medical care related to a car accident or work injury? □ **Yes** □ **No**

PLEASE NOTE

- For documentation of income, we only request recent paystubs or income tax returns. We accept, but do not require, other forms of documentation of income.
- Patients applying only for Financial Assistance may receive less financial assistance than what may be available to them under the Charity Care program.
- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION			
Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify _____)	Birth Date		Patient Social Security Number (optional*) **Optional, but needed for more generous assistance above state law requirements*
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*) **Optional, but needed for more generous assistance above state law requirements*
Mailing Address _____ _ _____ _ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____

Employment status of person responsible for paying bill.
□ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed: _____)
□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

FAMILY INFORMATION

List family members in your household, including you. "Family" includes the following: For persons 18 years of age and older, spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:
- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain_____)*

INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written and signed statement describing your income. Please provide proof for every identified source of income.

Proof of income means:

- Current pay stubs (within *3 months*); or
- Last year's income tax return, including schedules if applicable.

You may, but are not required to, provide additional proof of income beyond current pay stubs and last year's income tax return.

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (*child support, loans, medications, other*)

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that ***Kindred Hospital*** may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of Charity Care or Financial Assistance, and I may be responsible for and expected to pay for the services provided.

_____ _____

Signature of Person Applying Date