PIH HEALTH HOSPITAL REQUEST FOR FINANCIAL ASSISTANCE/UNCOMPENSATED SERVICES

I ask PIH Health Hospital to determine if I am eligible for help in paying for my hospital bill. I understand that I need to give certain information for this to be done. I understand that filling out this form does not guarantee that I will receive this help. If I am not eligible for uncompensated services, I am responsible for my hospital bill.

Name _____ Account number _____

Address _____ Phone number _____
Number Street City State Zip

Employer name _____ Employer phone _____

Employer address _____

Date of birth ___/___/___ Sex Code ___ 1=Male 2= Female

Name Relationship Age Gender

Number of family members living with you

Name Relationship Age Gender

Physician Name _____ Diagnosis _____

INCOME: PLEASE PROVIDE PHOTOCOPIES OF PAYCHECKS AND BANK STATEMENTS AND LIST INCOME

	Monthly	Annual
Wages (Self)		
(Spouse)		
(Other Family Member)		
Farm or self employment		
Public Assistance		
Social Security		
Unemployment Compensation		
Strike Benefits		
Allmony /Child Support		
Military Family Allotments		
Pensions		
Income from Dividends, Interest, Rent		

EXPENSES (Monthly)

Mortgage/Rent _____ (1)
Utilities _____
Telephone _____
Food _____
Finance/other loans _____
Auto Loans _____
(1) If none, source of housing _____

Medical Insurance _____
Auto Insurance _____
Medical Bills _____
Hospital _____
Physician _____
Medication _____
TOTAL EXPENSES _____

Do you own a home? Yes ( ) No ( ) If yes, estimated value: _____ Amount owed _____
Do you own other property? Yes ( ) No ( ) If yes, estimated value: _____
Do you own automobiles? Yes ( ) No ( ) If yes, Model/Make: _____ Year ___ Value _____

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I agree to tell the provider of services, within 10 days, if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses, or in the persons in the household or of any change of addresses.
- I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with my employer, bank, credit verification and property searches.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the hospital from proceeds of any litigation or settlement resulting from such act.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the services rendered by PIH Health Hospital or I may appeal decision in writing with additional documentation.

_____ _____
Signature Date

PIH HEALTH

PIH HEALTH

12401 Washington Blvd.
Whittier, CA 90602-1006
T: 562.698.0811

Hearing Impaired
TDD: 562.696.9267
PIHHealth.org

Date_____

Patient Name _____

Account number _____

Dear Mr./Mrs. _____,

We have carefully reviewed your application for financial assistance/uncompensated care and have determined that your account:

( ) Meets the Hospital's established guidelines for uncompensated services.

Approved amount $_____*
Your last payment posted on _____in the amount of $_____.

The account will be reduced by the above amount and the guarantor is responsible for $_____ payable at $_____ per month for ___ months.

If you have bills from physicians that provided care during your hospitalization at PIH Health Hospital, you may want to provide them with a copy of this letter. AB 1503 requires Emergency Room physicians to limit expected payment from eligible patients that are uninsured or have high medical costs whose income is at or below 400% of the federal poverty level. If you have a bill from an ER physician, please contact the physician's billing service to determine if you qualify for a discount.

( ) Does not meet the Hospital's established guidelines for uncompensated services.
Reason for denial:

_____ Monthly income exceeds qualifications.
_____ Potential third party payor source
_____ Application not complete.
_____ Supporting documentation not adequate.

If you have questions, please call the Customer Service Supervisor at (562) 698-0811, extension 14231.

Sincerely,

Uncompensated Care Committee

PIH HEALTH

12401 Washington Blvd.
Whittier, CA 90602-1006
T: 562.698.0811

Hearing Impaired
TDD: 562.696.9267
PIHHealth.org

Date: _____

Dear _____,

Thank you for choosing PIH Health Hospital for your health care needs.

Please promptly complete and return the attached application for financial assistance AKA uncompensated care. Additionally, please provide photocopies of your last two pay checks relating to any source(s) of income as well as photocopies of your last two bank statements.

Please call me at (562) 698-0811, extension 14231, if I can help answer any questions.

Sincerely,

Customer Service/Collection Supervisor