

**Canyon Ridge Hospital**  
Application for Discount or Charity  
*Solicitud de descuento o beneficencia*

It is the policy of Canyon Ridge Hospital, in compliance with California State law AB774 (Hospital Fair Pricing Policies) to provide discounts from standard billed charges for all self pay and high medical cost patients as defined above. To determine if you are eligible for discount or charity, please complete the following information (the business office staff will assist in completion of the form if requested) **Please note:** If you are applying for discount payment only, you may receive less financial assistance than what may be available under charity care:

*Es política de Canyon Ridge Hospital, según la ley estatal AB774 de California (Políticas de fijación de precios justos para hospitales), proporcionar descuentos en gastos estándares facturados para todos los pacientes que pagan por cuenta propia y pacientes con costos médicos elevados según se define a continuación. Para determinar si usted es elegible para un descuento o beneficencia, complete la siguiente información (el personal de la oficina comercial lo ayudará a completar el formulario si fuese necesario) **Tenga en cuenta:** si solicita pago con descuento únicamente, es posible que reciba menos asistencia financiera que la que puede estar disponible bajo atención caritativa:*

When applying for a Discount, the facility may only require confirmation of income through either recent paystubs or income tax returns. To apply for Discount only, please complete Section 1. To apply for Charity Care, please complete both Section 1 and Section 2.

*Al solicitar un descuento, es posible que el centro solo requiera confirmación de ingresos a través de talones de pago recientes o declaraciones de impuestos sobre la renta. Para solicitar el descuento únicamente, complete la Sección 1. Para solicitar Atención de caridad, complete la Sección 1 y la Sección 2.*

Section 1 (For Discount and Charity Care):

Patient Name (*Nombre del paciente*): \_\_\_\_\_

Patient account # (*Número de cuenta del paciente*): \_\_\_\_\_

Guarantor Name (*Nombre del garante*): \_\_\_\_\_

Annual income (*Ingreso anual*): \$ \_\_\_\_\_

(Note: annual income must be supported by either a current pay stub or your most recent income tax return).

(*Nota: el ingreso anual debe estar acompañado de un recibo de sueldo o su declaración de impuesto sobre las rentas más reciente*).

**Section 2 (For Charity Care ONLY):**

Number of persons in family or household (*Cantidad de personas de la familia o en la casa*): \_\_\_\_\_

Out of pocket medical expenses during the previous 12 months (including an estimate of your out of pocket costs for this hospitalization) (*Gastos médicos en efectivo durante los 12 meses anteriores (incluido un estimado de sus costos en efectivo para esta hospitalización)*): \_\_\_\_\_

Total monetary assets (excluding retirement or deferred compensation plans) (*Total de activos monetarios (sin incluir los planes de retiro o de compensación diferida)*): \$ \_\_\_\_\_

---

For completion by business office staff only.

1. Annual income \_\_\_\_\_
2. Federal Poverty Level (FPL) for family size \_\_\_\_\_
3. Line 1 as a percent of line 2 \_\_\_\_\_
4. Maximum payable by Medicare or Medi-Cal for stay \_\_\_\_\_
5. Total monetary assets \_\_\_\_\_

Insured patients only:

6. Expected out of pocket cost for this stay \_\_\_\_\_
7. Total out of pocket expenses-previous 12 months \_\_\_\_\_
8. Line 6 plus line 7 as a percent of line 1 \_\_\_\_\_

Discount for self-pay patients to be applied to the stay based on the following grid:

<b>Line 3 percent</b>	<b>Required discount</b>	<b>Approved discount</b>
Greater than 400%	0%	
251% to 400%	Higher of Medicare or Medi-Cal payment for stay	
101% to 250%	50% of the higher of Medicare or Medi-Cal payment for stay	
Up to 100% and line 5 less than \$10,000	100%	
Up to 100% and line 5 greater than \$10,000	0%. Total payment may not exceed amount of line 5 greater than \$10,000.	

Discount for insured patients to be applied to the stay based on the following grid:

<b>Line 3 percent</b>	<b>Required discount</b>	<b>Approved discount</b>
Greater than 400%	0%	
Less than 400% and line 8 is greater than or equal to 10%	Total payment received from insurance plus patient will not exceed 100% of the higher of Medicare or Medi-Cal payment	

Federal Poverty Guideline as of 01/12/26:

<b>Persons in Family or Household</b>	<b>48 Contiguous States and D.C.</b>	<b>Alaska</b>	<b>Hawaii</b>
1	\$15,960	\$19,950	\$18,360
2	21,640	27,050	24,890
3	27,320	34,150	31,420
4	33,000	41,250	37,950
5	38,680	48,350	4,480
6	44,360	55,450	51,010
7	50,040	62,550	57,540
8	55,720	69,650	64,070
For each additional person, add	5,680	7,100	6,530

\*A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.