COLLEGE MEDICAL CENTER

Patient Name: Patient Financial Number:

FINANCIAL ASSISTANCE APPLICATION

Patients who apply may be eligible for either Charity Care or Discount Payment.

CHARITY CARE: 100% of bill covered for those whose household income is 200% of less the Federal Poverty Level

DISCOUNT PAYMENT: A portion of bill discounted equal to Medicare or Medi-Cal rate, whichever is higher, for those whose household income is between 200% and 400% of the Federal Poverty Level

Schedule of Current Income and Expenditures

_____ _____

Patient's Name Spouse's Name

_____

Address

_____

Phone

Social Security Number: _____ _____

(Patient) (Spouse)

EMPLOYMENT AND OCCUPATION

_____

Employer

_____

Position

_____ _____

Contact Person

For any questions, please ***Contact: Business Office directly at 562-256-8314.***
Thank you in advance for your courtesy and prompt attention regarding this matter.

COLLEGE MEDICAL CENTER

If self-employed, give name of business

Spouse's Employer

Position

Contact Person

If self-employed, give name of business

For any questions, please ***Contact: Business Office directly at 562-256-8314.***
Thank you in advance for your courtesy and prompt attention regarding this matter.

COLLEGE MEDICAL CENTER

Patient Name: Patient Financial Number:

CURRENT MONTHLY INCOME

	Patient	Spouse
Gross pay from employment: (Before deductions)	$ _____	$ _____
Income from operating business: (If self-employed)	$ _____	$ _____
Tax Return:	$ _____	$ _____
Total current monthly income: (Add all figures from above)	$ _____	$ _____

NO INCOME AFFIDAVIT – Must initial the statement below. I,_____, herby certify that I have no job or assets, and no income other than potential donations from others.
Parent/Guarantor Initials _____

For any questions, please ***Contact: Business Office directly at 562-256-8314.***
Thank you in advance for your courtesy and prompt attention regarding this matter.

COLLEGE MEDICAL CENTER

Patient Name: Patient Financial Number:

FAMILY STATUS

List all dependents you support

Name	Age	Relationship

I certify that the above stated information is true and correct. I authorize Glendora Hospital to contact the employer's institutions on this application or a credit reporting agency to verify its accuracy. I further authorize the employers, institutions and/or credit reporting agencies to release such information to College Hospital.

(Date) (Signature of Patient or Guarantor)

(Date) (Signature of Spouse)

For any questions, please ***Contact: Business Office directly at 562-256-8314.***
Thank you in advance for your courtesy and prompt attention regarding this matter.

COLLEGE MEDICAL CENTER

Financial Assistance Application Instructions

If you are having trouble paying your medical bills, you may be eligible for financial assistance through College Medical Center (CHLB, LLC). Individuals whose family incomes is at or below 400% of the Federal Poverty Level and who are either uninsured or have high medical costs may qualify for Charity Care, Discounted Care, or reduced charges for services. To determine your eligibility for financial assistance complete this application and submit any required supporting documentation.

Patients whose household income is 200% less of the Federal Poverty Level are eligible for Charity Care. Patients whose household income is between 200% and 400% of the Federal Poverty Level are eligible for Discount Payments.

Additionally, you may be eligible for government programs such as Medi-Cal, which provide temporary Medi-Cal coverage based on self-reported patient information. For further details, please visit the following website:

https://files.medi-cal.ca.gov/pubsdoco/presuptive/eligibility/PEprogramslanding.aspx

Instructions for Completing the Financial Assistance application:

1. **Application Completion:** Please complete all fields on either the Charity Care or Discounted Pay applications. If any section does not apply to you, write “N/A” (Not Applicable) in the corresponding space.

2. **Discounted Pay:** Eligibility for Discounted Pay or any other service that is reduced but not free will be determined based on income in accordance with the Federal Poverty Level. Documentation of income is limited to recent pay stubs or income tax returns. Other forms of income documentation may be accepted but are not required. Patients must also undergo a screening process for Medi-Cal eligibility.

3. **Charity Care:** Eligibility for Charity Care will be based on income as per the Federal Poverty Level guidelines. Required documentation of income is limited to recent pay stubs or income tax returns. Other forms of income documentation may be accepted but are not required Patients must also participate in Medi-Cal eligibility screening.

For any questions, please ***Contact: Business Office directly at 562-256-8314.***
Thank you in advance for your courtesy and prompt attention regarding this matter.

COLLEGE MEDICAL CENTER

4. **Application Deadline:** Under HSC Section 12740(e)(3), eligibility for Discounted Pay or Charity Care may be determined at any time. College Medical Center (CHLB, LLC) does not impose time limits for applying for Charity Care or Discounted Pay and will not deny eligibility based on the timing of your application.

5. **Contact Information:** For assistance with the application, please contact the Patient Account Representative at 562-256-8314 or mail your completed application to:

COLLEGE MEDICAL
CENTER PO BOX 16421
LONG BEACH, CA 90806

For any questions, please ***Contact: Business Office directly at 562-256-8314.***
Thank you in advance for your courtesy and prompt attention regarding this matter.