Pipeline Health - Eligibility for Patient Financial Discount (Charity) Application &

INSTRUCTIONS

I. A// items/question on the application form must be completed for the application to be processed.

II. Patient signature & date is required. If guarantor/ spouse provides information as well, all must sign.

III. The attached worksheet proof of all income and supporting documentation must be received within 60 days of the initial patient billing.

IV. This application requires patient financial data.

V. The completed application & required documentation to be submitted to the applicable address are as follows:

Community Hospital of Huntington Park, 2623 E. Slauson Ave., Huntington Park, CA 90255, Attn: Admissions Dept.

Coast Plaza Hospital, 13100 Studebaker Road, Norwalk, CA. 90650, Attn: Admissions Dept

East Los Angeles Doctor's Hospital, 4060 E. Whittier Blvd, Los Angeles, CA 90023, Attn: Admissions Dept.

Central Business Office, 17871 Park Plaza Dr Ste 200 Cerritos, CA 90703

Memorial Hospital of Gardena, 145 West Redondo Beach Blvd., Gardena, CA 90247, Attn: Admissions Dept.

VI. **Was a federal income tax return (Form 1040) filed by patients for the most recent calendar year?**

Yes ☐ No ☐

If yes, a copy of the IRS return for the year of the first billing or 12 months prior including all pages and schedules must be submitted and is attached.

Yes ☐ No ☐

If no patient did not file a federal income tax return, the following items must be provided:

1. A statement explaining why patients did not file a federal tax return.
   Yes ☐ No ☐
2. Two (2) pay stubs within 6 months before or after the date of first billing from patient & family members residing in same household.
   Yes ☐ No ☐
3. The last two (2) months of any financial/ bank statements/accounts
   Yes ☐ No ☐ N/A ☐
4. If there is no patient income, documentation provided detailing how patient supports self/ /family.
   Yes, ☐ No ☐ N/A ☐

Name	Age	Relationship

VII. Does the patient currently have health insurance?

If yes, what insurance does the Patient have?

_____

VIII. Patient Information:

1. Patient Name: _____
2. Patient SSN (Acct.): _____-_____-_____
3. Patient Date of Birth_____
4. Patient Home Phone # _____
5. Patient Work Phone #_____
6. Patient Address: _____
7. Treating Facility: _____
8. Date of Service: _____

IX. Patient Family Household Information

1. Spouse Name_____
2. Spouse SSN: _____-_____
3. Spouse Birth Date: _____
4. List same household family members below*:

*List patient's spouse, domestic partner, and dependent children 21 years and under, whether living at home or not. List Parents and or Caretakers if Disabled.

X. Responsible Party/ Guarantor Information

1. Relationship to Patient: _____
2. Guarantor Name_____
3. Guarantor SSN: _____
4. Guarantor DOB: _____
5. Guarantor Phone: _____
6. Guarantor Home Address:

_____

_____

7. Guarantor Employer Name & Address: (If self-employed, give name of business)

_____

_____

8. Position: _____
9. Work Contact (Name): _____
10. Work Phone: _____

XI. Homeless Affidavit

Patients are currently homeless:

Yes ☐ No ☐

I, (Insert Signature) _____, hereby certify that I am homeless, have no permanent address, no job, savings or assets, and no income other than potential donations from others.

XII. Insurance (Third Party Payer) Information

1. Patients have applied for Medi-Cal or any other income-based/means evaluated government-sponsored coverage in the last 12 months?

   Yes ☐ No ☐

2. If yes, is patient's application still pending?

   Yes ☐ No ☐

3. If a decision reached, was patient awarded assistance?

   Yes ☐ No ☐

4. If yes, what amount was awarded? _____

5. If a decision was reached and assistance not awarded, please explain why the patient was denied?

   _____

   _____

   _____

   _____

6. Is a third party responsible for the medical care you will receive or have received (e.g., a work-related injury or auto accident)?

   Yes ☐ No ☐

7. If yes, please provide the party responsible for covering the losses (e.g., insurance carrier, claim #, contact phone number, etc.)

   _____

   _____

XIII. Financial Worksheets

A. Current Income

Type	Patient/ Guarantor	Spouse
1. Gross Wages & Salary/Year (before deductions)		
2. (Self-Employment) Income:		
3. Social Security/ Unemployment/ Disability/ Other Public Assistance		
4. Alimony/ Child Support		
5. Real Estate Rentals & Leases		
6. All Other Sources (attach list)		
7. Total Income (add all lines above)		

XIV. Guarantor Attestation

Patient declares under the penalty of perjury that all t information provided herein is true and correct to the best of his/her knowledge and further understands and agrees as follows:

- Providing false or misleading information, or the intentional omission of material information, will result in the denial of this application and could result in legal actions being taken against me/us.
- Patient authorizes Pipeline Health to verify any information listed in this application, including employment status and credit history, for the purpose of determining eligibility for patient discount.
- Patient fully understands that the Patient (Charity) Discount programs are a "Payor of Last Resort."
- Patient therefore hereby assign to Pipeline Health all benefits due from any liability action, personal injury claims, settlements, and all insurance benefits which may become payable, for illness/ injury for which Pipeline Health or its subsidiaries provided care.

NOTE: APPLYING FOR ONLY A DISCOUNTED PAYMENT MAY RESULT IN LESS FINANCIAL ASSISTANCE THAN APPLYING FOR FREE CARE UNDER THE CHARITY POLICY.

_____

Signature of Patient/Guarantor

_____

Date

_____

Signature of Spouse

_____

Date

_____

Sponsor

_____

Date