

The Natividad Financial Counseling Unit Application for Charity Care and Discount Programs is attached.

- Natividad may only request income tax returns or recent paystubs for documentation of income.
- Patients that only apply for the discount programs may receive less financial assistance than what may be available under the charity care program.

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.

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.

___ Tagline Language Attachment

English

ATTENTION: If you need help in your language, call (831) 796-1612 or visit Human Resources. The office is open 7:30 am to 5:00 pm Monday–Friday and located near to the Main Lobby. 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 (831) 796-1612 o visite Recursos Humanos. La oficina está abierta de 7:30 am a 5:00 pm, de lunes a viernes, y está ubicada cerca del vestíbulo principal. También se encuentran disponibles ayudas y servicios para personas con discapacidades, como documentos en braille, letra grande, audio y otros formatos electrónicos accesibles. Estos servicios son gratuitos.

Arabic

إتنبه: ذا كنت بحاجة إلى مساعدة بلغتك، فاتصل على الرقم 796-1612 (831) أو قم بزيارة الموارد البشرية. المكتب مفتوح من 7:30 صباحًا حتى 5:00 مساءً من الاثنين إلى الجمعة، وهو موجود بالقرب من الردهة الرئيسية. تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل الوثائق المكتوبة بطريقة برايل والمطبوعات الكبيرة والصوت وغيرها من التيسيلات الإلكترونية التي تناسب المعاقين. هذه الخدمات مجانية.

Armenian

Ուշադրություն. Եթե Ձեր լեզվով օգնության կարիք ունեք, զանգահարեք (831) 796-1612 հեռախոսահամարով կամ այցելեք մարդկային ռեսուրսների բաժին: Գրասենյակը բաց է 07:30-ից մինչև 17:00՝ երկուշաբթիից ուրբաթ օրերին, և գտնվում է գլխավոր նախասրահի մոտ: Հաշմանդամություն ունեցող անձանց համար հասանելի են նաև օժանդակ միջոցներ և ծառայություններ, ինչպիսիք են՝ բրայլյան, խոշոր տպագրությամբ փաստաթղթերը, աուդիո և այլ մատչելի էլեկտրոնային ձևաչափերը: Այս ծառայություններն անվճար են:

Cambodian

ចូរបំរមណ៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសាខ្មែរស្វ័យប្រវត្តិ ទូរស័ព្ទទៅ (831) 796-1612 ឬចូលទៅផ្នែកធនធាន មនុស្ស។ ការិយាល័យបើកដំណើរការពីម៉ោង 7:30 ព្រឹក ដល់ 5:00 ល្ងាច ថ្ងៃចន្ទ ដល់ថ្ងៃសុក្រ ហើយមានទីតាំង នៅជិត Main Lobby។ ជំនួយ និងសេវាកម្មជនពិការ ដូចជាឯកសារជាអក្សរសម្រាប់មនុស្សខ្វាក់ (braille) ការបោះពុម្ពធំ សម្លេង និងទម្រង់អេឡិចត្រូនិកដែលអាចចូលប្រើបានផ្សេងទៀតក៏មានផងដែរ។ សេវាកម្មទាំងនេះ ឥតគិតថ្លៃ។

Chinese

请注意：如果您需要语言帮助，请致电(831) 796-1612 或前往人力资源部。办公室位于主厅 (Main Lobby) 附近，营业时间为周一至周五上午7:30 至下午5:00。我们还为残障人士提供辅助工具和服务，如盲文、大字体、音频和其他无障碍电子格式文件。上述服务均免费。

請注意：如果您需要語言方面的幫助，請致電(831) 796-1612 或造訪人力資源部。辦公室開放時間為星期一- 星期五上午 7:30 至下午 5:00，地點位於主大廳附近。還提供針對殘障人士的幫助與服務，例如布拉耶點字法、大字體列印、音訊，以及其他無障礙電子格式的文件。這些服務都是免費的。

Farsi

اتوجه: گر به زبان خود به کمک نیاز دارید، با شماره 796-1612 (831) تماس بگیرید یا به بخش منابع انسانی مراجعه کنید. اداره از ساعت 7:30 صبح تا 5:00 بعدازظهر روزهای دوشنبه تا جمعه باز است و نزدیک لابی اصلی قرار دارد. کمک و خدمات مخصوص افراد دچار معلولیت، مانند اسناد با خط بریل، چاپ بزرگ، صوتی و سایر فرمتهای الکترونیکی قابلدسترس نیز موجود است. این خدمات رایگان است.

Hindi

ध्यान दें: यदि आपको अपनी भाषा में मदद चाहिए, तो (831) 796-1612 पर फोन करें या Human Resources के पास जाएं। ऑफिस, सोमवार से शुक्रवार सुबह 7:30 बजे से शाम 5:00 बजे तक खुला रहता है, और मेन लॉबी के पास स्थित है। विकलांग लोगों के लिए, ब्रेल, बड़े प्रिंट, ऑडियो और अन्य सुलभ इलेक्ट्रॉनिक फॉर्मेट्स में दस्तावेज जैसी सहायता और सेवाएं भी उपलब्ध हैं। ये सेवाएं निःशुल्क हैं।

Hmong

Xa Rau: Yog koj xav tau kev pab ua koj hom lus, hu rau (831) 796-1612 los sis mus cag Feem Saib Neeg Ua Hauj Lwm (Human Resources). Chav ua hauj lwm qhib thaum 7:30 teev sawv ntxov txog 5:00 teev tsaus ntuj hnuv Monday-Friday thiab nyob ze rau cheeb tsam Chav Tos Qhua Loj (Main Lobby). Kev pab thiab pab cuam rau cov neeg xiam oob qhab, xws li cov ntawv su, luam ua tus ntawv loj, ua suab, thiab lwm hom ntawv hauv es lev taus niv puav leej muaj pub. Cov kev pab cuam no yog pub dawb.

Japanese

注意：母国語でのサポートが必要な場合は、(831) 796-1612 に電話するか、人事部にお問い合わせください。オフィスは月～金曜日の午前7時30分～午後5時まで営業しており、メインロビーの近くにあります。点字、大活字、音声、その他のアクセシブルな電子形式の文書など、障害者用補助サービスもご利用いただけます。これらのサービスは無料です。

Korean

알림: 귀하의 언어로 도움을 받으려면 (831) 796-1612 로 전화하거나 인사과(Human Resources)를 방문하십시오. 사무실은 월요일 ~ 금요일, 오전 7 시 30 분 ~ 오후 5 시까지 운영하며, 메인 로비 근처에 있습니다. 점자, 큰 활자, 오디오, 및 기타 이용 가능한 전자 형식의 문서와 같이 장애인을 위한 지원 및 서비스도 제공해 드립니다. 이러한 서비스는 무료입니다.

Laotian

ສຳຄັນ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ໂທຫາ (831) 796-1612 ຫຼື ໄປຫາພາກສ່ວນບຸກຄາລະກອນ. ຫ້ອງການແມ່ນເປີດແຕ່ 7:30 ໂມງເຊົ້າ ຫາ 5:00 ໂມງແລງ ວັນຈັນ-ວັນສຸກ ແລະ ຫ້ອງການຢູ່ໃກ້ກັບຫ້ອງໂຖງໃຫຍ່. ມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການຄົນພິການເຊັ່ນ: ເອກະສານທີ່ເປັນຕົວອັກສອນນູນ, ພິມຕົວໜັງສືໃຫຍ່, ເປັນສຽງ ແລະ ຮູບແບບອີເລັກໂທຣນິກອື່ນໆທີ່ສາມາດເຂົ້າເຖິງໄດ້. ການບໍລິການເຫຼົ່ານີ້ແມ່ນຟຣີ.

Mien

Longc hnyouv jangx longx: Beiv hngv meih qiemx zuqc longc mienh tengx faan benx meih nyei waac bun muangx nor, douc waac lorx taux (831) 796-1612 a'fai bieqc mangc yiem goux mienh nyei dinc zangc gorn. Naaiv norm dinc zangc ze'weic gorn se koi zoux gong yiem 7:30 diemv lungx ndorm mingh taux 5:00 diemv lungx hmuangx yiem leiz baaix yietv - leiz baaix hmz aengx caux yiem njiec nitv fatv meih nyei deic jei dorngx wuov. Ninh mbuo mbenc duqv maaih jaa-dorngx aengx caux gong-bou jauv-louc tengx ziux goux wuaaic fangx mienh, dorh nyungc horngx sou zoux benx nzangc-pokc bun hluo, nqaapv bieqc domh zeiv-fangx, zoux benx waac-qiez bun muangx, aengx caux da'nyeic nyungc horngx gong yiem ga'nyuoz electronic bun longc oc. Naaiv deix gong-bou jauv-louc se wangv-henh tengx nzie hngv oc.

Punjabi

ਧਿਆਨ: ਯਦਿ ਆਪਕੋ ਅਪਨੀ ਭਾਸ਼ਾ ਮੇਂ ਮਦਦ ਚਾਹਿਏ, ਤੋ (831)796-1612 ਪਰ ਫੋਨ ਕਰੋਂ ਯਾ Human Resources ਕੇ ਪਾਸ ਜਾਓਂ। ਆਫਿਸ, ਸੋਮਵਾਰ ਸੇ ਸ਼ੁਕਰਵਾਰ ਸੁਬਹ 7:30 ਬਜੇ ਸੇ ਸ਼ਾਮ 5:00 ਬਜੇ ਤਕ ਖੁਲਾ ਰਹਤਾ ਹੈ, ਔਰ ਮੇਨ ਲੌਬੀ ਕੇ ਪਾਸ ਸਥਿਤ ਹੈ। ਵਿਕਲਾਂਗ ਲੋਗੋਂ ਕੇ ਲਿਏ, ਬ੍ਰੇਲ, ਬਡੇ ਪ੍ਰਿੰਟ, ਆਡਿਓ ਔਰ ਅਨਯ ਸੁਲਭ ਇਲੈਕਟ੍ਰੋਨਿਕ ਫੌਰਮੈਟਸ ਮੇਂ ਦਸਤਾਵੇਜ਼ ਜੈਸੀ ਸਹਾਯਤਾ ਔਰ ਸੇਵਾਏਂ ਭੀ ਉਪਲਬਧ ਹੈਂ। ਏ ਸੇਵਾਏਂ ਨਿਸ਼ੁਲਕ ਹੈਂ।

Russian

ВНИМАНИЕ: Если Вам требуется помощь на Вашем родном языке, позвоните по телефону (831) 796-1612 или посетите отдел кадров. Офис открыт с 7:30 до 17:00, с понедельника по пятницу, и расположен рядом с главной приемной. Также доступны приспособления и услуги для лиц с ограниченными возможностями, например, документы, напечатанные шрифтом Брайля, крупным шрифтом, в аудиозаписи и других доступных электронных форматах. Эти услуги предоставляются бесплатно.

Tagalog

Atensiyon: Kung kailangan mo ng tulong sa iyong wika, tumawag sa (831) 796-1612 o bisitahin ang visit Human Resources. Ang opisina ay bukas mula 7:30 ng umaga hanggang 5:00 ng hapon Lunes - Biyernes at matatagpuan malapit sa Main Lobby. Ang mga tulong at serbisyo sa mga taong may kapansanan, gaya ng mga dokumentong naka-braille, malalaking imprinta, audio, at iba pang accessible electronic format ay available rin. Ang mga serbisyonang ito ay libre.

Thai

โปรดทราบ: หากคุณต้องการความช่วยเหลือในภาษาของคุณ โปรดโทรไปที่ (831) 796-1612 หรือไปที่ฝ่ายทรัพยากรบุคคล สำนักงานเปิดทำการตั้งแต่ 7.30 น. ถึง 17.00 น. วันจันทร์ถึงวันศุกร์ และตั้งอยู่ใกล้กับห้องโถงหลัก มีสิ่งอำนวยความสะดวกและบริการสำหรับบุคคลที่มีความทุพพลภาพด้วยเช่นกัน เช่น เอกสารในอักษรเบรลล์ เอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ เอกสารเสียง และเอกสารในรูปแบบอิเล็กทรอนิกส์อื่น ๆ ที่สามารถเข้าถึงได้ ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Ukrainian

УВАГА: Якщо вам потрібна допомога вашою мовою, телефонуйте (831) 796-1612 або зверніться до відділу кадрів. Відділ працює з понеділка по п'ятницю з 7:30 до 17:00, і розташований біля головного вестибюля. Також пропонуються допоміжні засоби й послуги для людей із обмеженими можливостями: як-от документи, написані шрифтом Брайля, великим шрифтом, аудіоматеріали та інші електронні формати, створені для людей із обмеженими можливостями. Ці послуги надаються безплатно.

Vietnamese

Nơi nhận: Nếu quý vị cần được giúp đỡ bằng ngôn ngữ của quý vị, hãy gọi (831) 796-1612 hoặc tới phòng Nhân Sự. Văn phòng mở cửa từ 7:30 am đến 5:00 pm Thứ Hai - Thứ Sáu và gần Sảnh Chính (Main Lobby). Các biện pháp trợ giúp và dịch vụ cho người khuyết tật, như tài liệu bằng chữ nổi Braille, bản in khổ lớn, âm thanh, và các định dạng điện tử phù hợp với người khuyết tật khác cũng có sẵn. Các dịch vụ này miễn phí.

Section 1: Applicant Information

First Name: _____ Middle: _____ Last Name: _____
DOB: _____ ☐ M ☐ F SSN#: _____ ITIN#: _____
Home Address: _____ City: _____ Zip Code: _____
Mailing Address: _____ City: _____ Zip Code: _____
Are you homeless? ☐ Yes ☐ No County/State in which you reside in: _____
Best contact number: ☐ Home ☐ Cell ☐ Work ☐ Message Phone Number: _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Registered Domestic Partner
Are you pregnant? ☐ Yes ☐ No Expected delivery date: _____

Section 2: Household Information

List all the people currently living in your home:

***For additional household member(s), please notify worker.**

Name: _____	Relationship: _____	Date of Birth: _____
Name: _____	Relationship: _____	Date of Birth: _____
Name: _____	Relationship: _____	Date of Birth: _____
Name: _____	Relationship: _____	Date of Birth: _____

Do you pay rent or mortgage? ☐ Rent ☐ Mortgage ☐ None Payment amount: _____

Are you receiving free housing or work in exchange for free housing? ☐ Yes ☐ No

Name of provider: _____ Relationship: _____

Section 3: Other Coverage Information

Have you applied for Medi-Cal benefits? ☐ Yes ☐ No If yes, date of application: _____

Do you have any other health coverage? ☐ Yes ☐ No

*** If yes, check the options that apply to you.**

☐ Health Insurance ☐ Medicare ☐ V.A. Insurance ☐ Auto Insurance ☐ Medi-Cal Share of Cost
☐ Other: _____

Section 4: Income Information

Are you currently employed? ☐Yes ☐No If yes, how often paid? ☐Weekly ☐Bi-Weekly ☐Monthly

Name of employer: _____

Is your spouse/partner employed? ☐Yes ☐No If yes, how often paid? ☐Weekly ☐Bi-Weekly ☐Monthly

Name of employer: _____

Are you or your spouse/partner self-employed? ☐Yes ☐No

Name of business: _____ Type of business: _____

Are you or your spouse/partner receiving income from the following:

***Please check the options below that apply to you.**

- ☐Unemployment ☐State Disability ☐Social Security ☐Worker's Compensation ☐Retirement
☐Pension ☐Spousal Support ☐Child Support ☐Student Financial Aid ☐G.A./Public Assistance
☐Food Stamps ☐None

Do you or your spouse/partner file taxes? ☐Yes ☐No Tax year last filed: _____

If you did not file, please state the reason why: _____

Do you or your spouse/partner receive income from the following:

***Please check the options below that apply to you.**

- ☐Home Property ☐Commercial Buildings ☐Private land ☐Commercial Land ☐None
☐Other: _____

Do you or your spouse/partner have other income not listed above? ☐Yes ☐No

If yes, please describe: _____ How often paid? _____

Section 5: Third Party Injury Information

Have you had any injuries or accidents within the past five (5) years? ☐Yes ☐No

***If yes, describe your injury below. If more than one injury, please notify worker.**

☐Auto Injury ☐Work Injury ☐Fall ☐Assault ☐Other: _____

Describe your injury: _____

Date of injury: _____ Are you pursuing any legal action? ☐Yes ☐No

Was there a settlement? ☐Yes ☐No Date of settlement: _____

I declare under penalty of perjury that the above statements are true and correct. I understand that my statements are subject to verification. I also understand that if I give false statements or withhold information the applicant will be discontinued from the program and may be prosecuted for fraud.

Applicant's Signature: _____ Date: _____

Print Name: _____

Co-Applicant's Signature (if applicable): _____ Date: _____

Print Name: _____

Authorized Representative Signature: _____ Date: _____

Print Name: _____ Relationship: _____

Applicant Rights & Responsibilities

Persons Requesting Assistance Through the Natividad Financial Counseling Unit Have the Following Rights:

1. The right to request an interpreter.
2. The right to be treated fairly and equally regardless of age, sex, sexual orientation, race, economic status, disability, medical condition, educational background, marital status, registered domestic partner status, religion, ancestry, national origin or the source of payment for care.
3. The right to apply for financial assistance for medical care and to be informed in writing of non-approval for Financial Counseling Unit programs, even if the program representative determines that the applicant may not qualify.
4. The right to review information concerning Financial Counseling Unit programs.
5. The right to have all personal information given to the Financial Counseling Unit held confidential under the HIPAA Privacy Rule Act.
6. The right to file a written appeal for any action taken by the Financial Counseling Unit, within ten (10) working days of the notice.

The Applicant Has the Responsibility to Notify the Financial Counseling Unit Within Ten (10) Days If:

1. The residence and/or mailing address of the applicant has changed.
2. An absent child or parent return to the home.
3. The applicant, applicant's domestic partner or wife becomes pregnant.
4. A minor child is adopted by the applicant or is awarded legal guardianship over a minor.
5. The applicant becomes physically or mentally impaired.
6. The applicant applies for Social Security benefits under the Department of Social Security Administration.
7. The applicant is awarded benefits through the: Department of Social Security Administration, Veterans Administration or under the Railroad Retirement Programs.

The Applicant Has the Responsibility to:

1. Consider applying for health care resources that may be available to the applicant and notify a representative from the Financial Counseling Unit department of final determinations.
2. Consider applying for any income which may be available to applicant.
3. Report any health care coverage that the applicant is entitled to use or receives before using the eligibility under the Financial Counseling Unit program.
4. Report any injuries and accidents. This includes self-injuries, injuries under Worker's Compensation, Motor Vehicle Accidents, assaults, etc.
5. Report any health care services received as a result of an accident or injury caused by a third party.
6. Reimburse the county for health care services received through Monterey County programs when a payment has been received due to an injury or accident to which you are applying for assistance.
7. Provide legal documentation of a written authorization representing or acting on behalf of the applicant in case the applicant is unable to complete the application process.

Applicant's Declaration:

- I declare that the rights and responsibilities have been presented to me.
- I declare that I fully understand my responsibilities and will fulfill the requirements as mentioned above.
- I declare under penalty of perjury that the information on the application is true to the best of my knowledge.
- I understand that I may be asked to prove my statements and that my statements are subject to verification by my employer, personal banks, credit agencies, property searches, etc.
- I understand that if I deliberately make false statement or withhold any information, I will be discontinued from the program and may be prosecuted for fraud as a result of my actions.
- I hereby authorize the Financial Counseling Unit to obtain and release medical, financial and eligibility information, necessary to determine eligibility, process claims or to perform utilization review and case management.
- A photocopy of this authorization shall be valid as the original.

Applicant's Signature: _____ Date: _____

Print Name: _____

Co-Applicant's Signature (if applicable): _____ I _____ Date: _____

Print Name: _____

Authorized Representative Signature: _____ Date: _____

Print Name: _____ Relationship: _____

Signature of Eligibility Worker: _____ Date: _____

Print Name: _____ Title: _____