San Joaquin General Hospital
Financial Assistance Form Instructions

This is an application for financial assistance at **San Joaquin General Hospital.**

We have two types of financial assistance – **Charity Care** and **Discount Payment** . You may qualify for free care or discounted care based on your family size and income. To view our financial assistance policy, please go to **https://www.sanjoaquingeneral.org/help-paying-your-bill.**

What does financial assistance cover? If you are not eligible for a government program and meet certain low- and moderate- income requirements, you may qualify for financial assistance. We provide financial assistance to help qualified patients pay for healthcare based on their financial need. This includes emergency, urgent, or medically necessary care. Patients who qualify get some or all of their costs covered regardless of whether they have healthcare coverage, or are uninsured, or are underinsured.

Physicians who practice at San Joaquin General Hospital are not included in this policy. If you need assistance with the physician bill, you will need to contact the physician's private office and speak to the office staff.

If you have questions or need help completing this application: You may obtain help for any reason, including language assistance, by calling our **Medical Financial Assistance Program** at **(209) 468-6679** Monday through Friday, 8 a.m. to 4:30 p.m. You may also visit the website above.

In order for your application to be processed, you must:

- Provide us information about your family
- Provide us information and documentation about your family's gross monthly income (income before taxes and deductions). *See* Income & Family Household Size section in the financial assistance application for additional information
- Attach additional information/documents if needed
- Sign and date the form

Mail completed application and supporting documents to:

San Joaquin General Hospital Attn: Medical Financial Assistance Program
500 West Hospital Road
French Camp, CA 95231

You may also submit the application and supporting documents in person at the same address. We will notify you of the final determination of eligibility and appeal rights, if applicable, within 30 days of receiving a complete application and supporting documents. If your application is incomplete, you will receive a letter or call requesting

the required documents to process your application. By submitting a financial assistance application, you give consent to make necessary inquiries to confirm financial obligations and information.

Additional Resources: The Health Consumer Alliance ("HCA") is a resource available to patients to help them understand the billing and payment process, as well as Covered California and Medi-Cal Presumptive Eligibility. HCA offers free assistance over-the-phone or in-person. For more information, visit the Health Consumer Alliance website at https://healthconsumer.org.

Shoppable Services: In compliance with the No Surprise Billing Act (Title 45 section 180.60 of the Code of Federal Regulations), please see the Hospital's tool of shoppable services available at https://rca.centaurihs.com/ptapp/#9150f7c69ef6e33ccd3eab7900459e38729dcdbe49a0561ed9dd8d5b35f7449a

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Please note we cannot guarantee that you will qualify for financial assistance, even if you apply.

Please fill out all the information completely. If it does not apply, write "NA." Attach additional pages if needed.

Application Date:	**Service Date:**
Social Security #: (optional)	❑ I do not have a Social Security #
Patient Name:	**Patient Birthdate:**
Account Number:	**Phone #:** ❑ Home ❑ Cell
Street Address, City, State & Zip:	
Is patient currently unhoused? Yes ❑ No ❑	

Please call our **Medical Financial Assistance Department** at **(209) 468-6679**, Monday through Friday, 8 a.m. to 4:30 p.m. for any questions about filling out this form.

Please check the type of financial assistance you are interested in applying for:

- ☐ Charity Care
- ☐ Discount Payment Program

Income requirements:

Charity Care: Current pay stubs and/or the most recent Income tax return(s).

Discount Payment: Income tax returns for the year in which the patient was first billed or 12 months prior to when the patient was first billed, or paystubs within a 6-month period before or after the patient is first billed by the hospital.

Questionnaire:	**Yes**	**No**
Do you need an interpreter? If yes, list preferred language _____		
Was the patient a resident of California at the time of service?		
Were the medical services received related to a motor vehicle accident, 3rd party injury, or workers' compensation? ***If yes, what is the date of injury?*** _____		
Did the patient have any active health insurance at the time of service?		
Was the patient an active Medi-Cal recipient at the time of service? ***If yes, please attach a copy of your health insurance or Medi-Cal card to this application.***		

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Are you or will you be disabled for more than 1 year?		
Are you a veteran of the armed forces?		
If female, have you been diagnosed with breast or cervical cancer?		
Are you seeking assistance for reproductive health needs *(pregnancy or contraceptive request)*?		
Do you or your family members have any other conditions for which you are seeking treatment or need assistance?		

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INCOME & FAMILY HOUSEHOLD SIZE:

- All adult *family* members' income must be disclosed. Income includes gross (before taxes and deductions). Sources of income include, for example: wages, unemployment, self-employment, worker's compensation, social security benefits, and other public assistance.
- "Family" is defined as: (1) for persons 18 years of age and older - spouse, domestic partner, and dependent children, whether living at home or not; and (2) for persons under 18 years of age, parent, caretaker relatives, and other children of the parent or caretaker relative.

Family Member's Name	Date of Birth	Relationship to Patient	Income Source or Employer Name	Amount based on Financial Assistance Program
				$
				$
				$
				$
				$
				$
				$
				$

- **Proof of Income from all sources MUST be supplied with this application (e.g., pay stubs, tax return (IRS Form 1040), etc.)**

- **If you report $0 income,** please provide a written statement of how you (or the patient) are surviving financially, including who provides food, shelter, transportation, etc., and how long you have been without income.

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CURRENT EXPENSES (Past 12 months from application date)

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Medical Expenses** (hospital, doctor, dental, vision, prescriptions, etc.)	$	Health Insurance Premiums** (medical, dental, vision)	$

****Please provide all receipts/Explanation of Benefits noted above whether paid or unpaid.**

ADDITIONAL INFORMATION	
Please attach an additional page if there is information about your current financial situation that you would like us to know, such as financial hardship, excessive medical expenses, or seasonal or temporary income.	
PATIENT AGREEMENT	
I understand that **San Joaquin General Hospital** may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans. I affirm that the above information is true and correct to the best of my knowledge. I understand that if the information I provide is determined to be false, financial assistance may be denied, and I may be responsible to pay for services provided.	
Date:	(Signature of Applicant or Guarantor)
Date:	(Signature of Spouse)

**We want to help. Please submit your application promptly.
You may continue to receive billing statements until we
receive your completed application and supporting documents.**