Financial Assistance Application Instructions

If you need help paying your medical bill, you may be eligible for financial assistance from Kentfield Hospital. Any individual whose family income is at or below 400% of the federal poverty level and is either uninsured or has high medical cost may be eligible for the hospital's charity (free) care or discounted care. To determine eligibility for financial assistance please follow the instructions below in completing the financial assistance application, including submission of supporting documentation, as applicable.

You may be eligible for government programs such as Medi-Cal and other government-funded healthcare assistant programs. Additionally, you are welcome to obtain applications for coverage offered through the California Health Benefit Exchange: www.coveredca.com.

Completion:

Please complete all areas on the attached application form. If any area does not apply to you, please write N/A (not applicable) in the space provided.

Discounted Care:

For purposes of determining eligibility for discounted care, we request that you submit documentation of income limited to (i) pay stubs within three months before or after the patient is first billed or (ii) income tax returns from the year the patient was first billed or 12 months prior to when the patient was first billed. Patients that only apply for discounted care may receive less financial assistance than what may be available to them under the charity care program. If you only wish to apply for discounted care, please complete page two and three and date Page Six of the application.

Charity (Free) Care:

For purposes of determining eligibility for charity care, please complete the entire application and write NA for any sections that are not applicable.

Submission:

If you have questions, please call 209-488-4820. Mail or deliver your completed application in person to: Kentfield hospital Business Office, 5258 Pirrone Court. Salida, 95368.

PATIENT FINANCIAL ASSITANCE APPLICATION

For discounted Care, please fill out pages 2 – 3 and sign and date page 5.
For Charity Care, please fill out the entire application (pages 2 – 5).

ACCOUNT/MEDICAL RECORD#:_____

Patient Information:

_____
Name:

_____
Social Security Number:

_____
Street Address:

_____
City/State/Zip:

_____
Employer:

_____
Occupation

_____
Phone:

_____
Work phone:

Spouse/Parent/Guarantor information:

_____
Name:

_____
Social Security Number:

_____
Street Address:

_____
City/State/Zip:

_____
Employer:

_____
Occupation

_____
Phone:

_____
Work phone

LIST ALL DEPENDENTS

Name:	Relationship:	Age:

FINANCIAL ASSISTANCE APPLICATION

MONTHLY INCOME

Gross Monthly Wages (before deduction)	
Patient/Responsible Party	Spouse
Monthly Wages:	Monthly Wages:
Other Income	
Interest & Dividends:	Interest & Dividends:
Real Estate Rental/Lease:	Real Estate Rental/Lease:
Social Security:	Social Security:
Unemployment/Disability:	Unemployment/Disability:
Alimony/Child Support:	Alimony/Child Support:

For Discounted Care Only, you may skip page 4. Sign and date page 5.

For Charity Care, please fill out the remainder of the application and sign and date on page 5.

MONTHLY EXPENSES

Monthly Expenses:	Amount:
Rent/Mortgage	
Alimony	
Child Support	
Childcare/School	
Food/Supplies	
Utilities (Gas, electric, water, phone etc.)	
Insurance Premiums (Medical, home, auto)	
Auto Payments	
Transportation Expenses (Fuel, repair cost	
Credit Card/Personal Loan Payments	
Current Medical Payments	
Other (Please provide description)	

FINANCIAL ASSISTANCE APPLICATION

By signing below, I/We declare that all information provided is true and correct to the best of my/our knowledge.

I/We authorize Kentfield Hospital to verify any information listed in this application.

_____
Patient Signature

_____
Date

_____
Spouse Signature

_____
Date

_____
Parent/Guardian

_____
Date