APPLICATION INSTRUCTIONS

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

2. Attach an additional page if you need more space to answer any question.

3. You ***must*** provide proof of income documents when you submit this application. The following documents are accepted as proof of income:

    - IRS tax returns
    - Payroll Stubs
    - Declarations
    - Other forms used to substantiate the need for Discount Care consideration
    - Letters

4. Your application cannot be processed until *all the required* information is provided. This information will be eligible for 6 months.

5. It is important that you complete and submit the Confidential Financial Assistance Application along with all required attachments within fourteen {14) days.

6. You must sign and date the application. If the patient/guarantor and spouse provide information, both must sign the application.

7. If you have any questions, please call the business office at {818) 904-3644.

8. Send your complete application to:
   Mission Community Hospital
   Patient Financial Services Department
   14850 Roscoe Blvd.
   Panorama City, CA 91402

The Department of Health & Human Services (HHS) issues poverty guidelines that are often referred to as the "federal poverty level" (FPL). Federally facilitated Marketplaces will use the 2023 guidelines when making calculations for the insurance affordability programs starting November 1, 2015.

HHS Poverty Guidelines: User Selection of Year, State, and Guideline Percentage

Dollars Per Year

Household/ Family Size	*25%*	*50%*	*75%*	*100%*	*150%*	*200%*	*250%*
1	3,645.00	7,290.00	10,935.00	14,580.00	21,870.00	29,160.00	36,450.00
2	4,930.00	9,860.00	14,790.00	19,720.00	29,580.00	39,440.00	49,300.00
3	6,215.00	12,430.00	18,645.00	24,860.00	37,290.00	49,720.00	62,150.00
4	7,500.00	15,000.00	22,500.00	30,000.00	45,000.00	60,000.00	75,000.00
5	8,785.00	17,570.00	26,355.00	35,140.00	52,710.00	70,280.00	87,850.00
6	10,070.00	20,140.00	30,210.00	40,280.00	60,420.00	80,560.00	100,700.00
7	11,355.00	22,710.00	34,065.00	45,420.00	68,130.00	90,840.00	113,550.00
8	12,640.00	25,280.00	37,920.00	50,560.00	75,840.00	101,120.00	126,400.00
Add for each additional person	1,285.00	2,570.00	3,855.00	5,140.00	7,710.00	10,280.00	12,850.00

Dollars Per Month

Household/ Family Size	**25%**	**50%**	**75%**	**100%**	**150%**	**200%**	**250%**
1	303.75	607.50	911.25	1,215.00	1,822.50	2,430.00	3,037.50
2	410.83	821.67	1,232.50	1,643.33	2,465.00	3,286.67	4,108.33
3	517.92	1,035.83	1,553.75	2,071.67	3,107.50	4,143.33	5,179.17
4	625.00	1,250.00	1,875.00	2,500.00	3,750.00	5,000.00	6,250.00
5	732.08	1,464.17	2,196.25	2,928.33	4,392.50	5,856.67	7,320.83
6	839.17	1,678.33	2,517.50	3,356.67	5,035.00	6,713.33	8,391.67
7	946.25	1,892.50	2,838.75	3,785.00	5,677.50	7,570.00	9,462.50
8	1,053.33	2,106.67	3,160.00	4,213.33	6,320.00	8,426.67	10,533.33
Add for each additional person	107.08	214.17	321.25	428.33	642.50	856.67	1,070.83

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

ase attach to this application your Proof of Income documentation for each income earner for the most current 3 month period. This may include paycheck stubs, employer income

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

'Chart is for 48 contiguous states and the District of Columbia; for Hawaii and Alaska please visit the website of the HHS Assistant Secretary for Planning and Evaluation ASPE): http://aspe.hhs.gov/poverty/poverty.cfm.

'*Dollar amounts are calculated based on 100% column; rounding rules may vary across federal, state, and local programs.

:very year, the perimeters of the Federal Poverty Level (FPL) increase based on the cost of living. Families need to understand where they fall on the FPL so they know whether they are eligible for Medicaid in their state or whether they are eligible for a federal subsidy because they earn between 100 and 400 percent of the FPL, or whether they are eligible for a tax credit because they purchased a Silver plan and earn less than 250 percent of the FPL.

To qualify for Cost-Sharing, one must be enrolled in a Silver level plan through a Marketplace
Cost-sharing reductions are not available for coverage purchased outside of the Marketplace.

Individuals and families with household incomes generally up to 250% of the FPL may be eligible to receive cost-sharing reductions. Household income is determined by calculating a consumer's modified adjusted gross income (MAGI). Members of federally recognized tribes may qualify for additional cost-sharing benefits.

Mission Community Hospital®
Compassionate Healthcare. Quality Healthcare.

PATIENT & FAMILY FINANCIAL STATEMENT
OF ASSETS, INCOME & EXPENSES

PATIENT, NAME _____ **ACCT #** _____ **DOS** _____

RESPONSIBLE PARTY

NAME	MARITAL STATUS	SOCIAL SECURITY NUMBER - -	
STREET ADDRESS CITY, STATE ZIP	LENGTH AT THIS ADDRESS	HOME PHONE ( ) -	
EMPLOYER NAME STREET ADDRESS CITY, STATE ZIP	IF UNEMPLOYED, HOW LONG	BUSINESS PHONE ( ) -	
OCCUPATION / TITLE	MONTHLY EARNINGS – GROSS $	MONTHLY EARNINGS – NET $	CURRENT EMPLOYMENT LENGTH YR / MO

RESPONSIBILE PARTY - SPOUSE

NAME		SOCIAL SECURITY NUMBER - -	
EMPLOYER NAME STREET ADDRESS CITY, STATE ZIP	IF UNEMPLOYED, HOW LONG	BUSINESS PHONE ( ) -	
OCCUPATION / TITLE	MONTHLY EARNINGS – GROSS $	MONTHLY EARNINGS – NET $	CURRENT EMPLOYMENT LENGTH YR / MO

RESPONSIBLE PARTY - DEPENDENTS

DEPENDENT NAME [YEAR OF BIRTH] #1 #2 #3 #4	TOTAL NUMBER OF DEPENDENTS IN HOUSEHOLD	DO ANY OTHER PERSONS CONTRIBUTE TO MONTHLY INCOME? YES NO IF YES, AMOUNT $

ASSETS & INCOME PER MONTH

INTEREST / DIVIDENDS $	WORKER'S COMPENSATION $	OTHER INCOME $
FOOD STAMPS / PUBLIC ASSISTANCE $	CHILD SUPPORT / ALIMONY $	IRA BALANCE $
SOCIAL SECURITY $	RENTAL INCOME $	CHECKING ACCOUNT BALANCE $
UNEMPLOYMENT COMPENSATION $	GRANTS $	SAVINGS ACCOUNT BALANCE $

EXPENSES PER MONTH

RENT $	AUTO # 1 PAYMENT $ AUTO # 1 BALANCE $	CHILD SUPPORT $
MORTGAGE PAYMENT $ MORTGAGE BALANCE $	AUTO # 2 PAYMENT $ AUTO # 2 BALANCE $	VISA PAYMENT $ VISA BALANCE $
FOOD $	AUTO EXPENSES $	MASTERCARD PAYMENT $ MASTERCARD BALANCE $
UTILITIES $	AUTO INSURANCE $	DISCOVER PAYMENT $ DISCOVER BALANCE $
PHONE $	HEALTH INSURANCE $	OTHER CREDIT CARD PMT $ OTHER CREDIT CARD BAL $
WATER / SEWER $	LIFE INSURANCE $	INSTALLMENT LOAN PMT $ INSTALLMENT LOAN BAL $
CABLE $	MEDICAL/DENTAL PMT $ MEDICAL/DENTAL BAL $	MISCELLANEOUS EXPENSE $
TRASH $	PHYSICIAN PAYMENT $ PHYSICIAN BALANCE $	MISCELLANEOUS EXPENSE $

OFFICE USE ONLY

TOTAL INCOME GROSS $
TOTAL INCOME NET $
TOTAL EXPENSES $
NET INCOME (LOSS) $

TO MY KNOWLEDGE THE INFORMATION PROVIDED ABOVE IS TRUE. I AUTHORIZE A CREDIT BUREAU REPORT TO BE SECURED BY THE HOSPITAL OR ITS AGENT TO VERIFY MY FINANCIAL STANDING.

_____
PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE

Please attach to this application your Proof of Income documentation for each income earner for the most current 3 month period. This may include paycheck stubs, employer income verification, W2, tax returns, Social Security letters and letters from family members certifying support amount provided.

Mission Community Hospital
Compassionate Healthcare. Quality Healthcare.

DECLARACIÓN FINANCIERA DEL PACIENTE Y FAMILIA -- PATRIMONIO, INGRESOS Y GASTOS

NOMBRE DEL PACIENTE _____ **CUENTA #** _____ **DOS**_____

PARTE RESPONSABLE

NOMBRE	ESTADO CIVIL	NÚMERO DE SEGURO SOCIAL	
DOMICILIO, CIUDAD, ESTADO, CÓDIGO POSTAL	AÑOS VIVIDOS EN ESTE LUGAR	TELÉFONO PARTICULAR ( ) -	
NOMBRE DE LA PERSONA O COMPAÑÍA QUE LO EMPLEA DOMICILIO CIUDAD,ESTADO, CÓDIGO POSTALP	SI HA ESTADO DESEMPLEADO, ¿POR CUANTO TIEMPO?	TELÉFONO EN EL EMPLEO ( ) -	
Ocupación/Título	GANANCIAS MENSUALES EN BRUTO $	GANANCIAS MENSUALES NETAS $	EMPLEO ACTUAL TIEMPO AÑO/MES

PARTE RESPONSIBLE/ ESPOSO O ESPOSA

NOMBRE		NÚMERO DE SEGURO SOCIAL - -	
NOMBRE DE LA PERSONA O COMPAÑÍA QUE LO/ LA EMPLEA DOMICILIO CIUDAD, ESTADO, CÓDIGO POSTAL	SI HA ESTADO DESEMPLEADO(A), ¿POR CUANTO TIEMPO?	TELÉFONO EN EL EMPLEO ( ) -	
OCUPACIÓN / TÍTULO	GANANCIAS MENSUALES – EN BRUTO $	GANANCIAS MENSUALES – NETAS $	EMPLEO ACTUAL TIEMPO AÑO / MES

PARTE RESPONSIBLE - DEPENDIENTES

NOMBRE DEL DEPENDIENTE [AÑO EN EL QUE NACIÓ] # 1 # 2 # 3 # 4	¿NÚMERO TOTAL DE DEPENDIENTES EN EL HOGAR?	OTROS EN EL HOGAR QUE CONTRIBUYAN ECONOMICAMENTE ¿INGRESOS? SI NO SI LA RESPUESTA ES SI, EL MONTO $

PATRIMONIO E INGRESOS MENSUALES

INTERESES / DIVIDENDOS $	COMPENSACIÓN AL TRABAJADOR $	OTROS INGRESOS $
BONOS ALIMENTICIOS (FOOD STAMPS) / ASISTENCIA PÚBLICA $	APOYO ECONÓMICO AL INFANTE O INFANTES / PENSIÓN EMANADA DE DIVORCIO $	SALDO DE CUENTA INDIVIDUAL DE JUBILACIÓN (IRA BALANCE) $
SEGURO SOCIAL $	INGRESOS POR RENTA(S) $	ESTADO DE SU CUENTA BANCARIA CORRIENTE $
COMPENSACIÓN POR DESEMPLEO $	BENEFICIOS (GRANTS) $	ESTADO DE SU CUENTA DE AHORROS $

GASTOS MENSUALES

RENTA $	AUTO # 1 PAGO $ AUTO # 1 SALDO $	AYUDA FINANCIERA -- HIJO O HIJOS $
PAGOS HIPOTECARIOS $ SALDO HIPOTECARIO $	AUTO # 2 PAGO MENSUAL $ AUTO # 2 SALDO $	PAGO DE TARJETA VISA $ SALDO DE TARJETA VISA $
ALIMENTOS $	GASTOS RELACIONADOS CON EL AUTO $	PAGO DE TARJETA MASTERCARD $ SALDO DE TARJETA MASTERCARD $
SERVICIOS PÚBLICOS (GAS, AGUA, ELECTRICIDAD, ETC.) $	SEGURO DE AUTO $	PAGO DE TARJETA DISCOVER $ SALDO DE TARJETA DISCOVER $
TELÉFONO $	SEGURO DE SALUD $	PAGO DE OTRA TARJETA DE CRÉDITO $ SALDO DE OTRA TARJETA DE CRÉDITO $
AGUA / ALCANTARILLADO $	SEGURO DE VIDA $	PAGO -- PRÉSTAMO A PLAZOS $ SALDO DEL PRÉSTAMO $
CABLE $	PAGOS --MEDICINA/DENTISTA $ SALDO DEL MONTO TOTAL $	GASTOS DIVERSOS $
SERVICIO DE BASURA $	PAGOS AL DOCTOR $ SALDO $	GASTOS DIVERSOS $

OFFICE USE ONLY TOTAL DE INGRESOS EN BRUTO $ TOTAL DE INGRESOS NETOS $ TOTAL DE GASTOS $ INGRESOS NETOS $	DE ACUERDO A MIS CONOCIMIENTOS, LA INFORMACIÓN PROPORCIONADA AQUÍ ARRIBA ES FIDEDIGNA. AUTORIZÓ UN REPORTE SOBRE MI SOLVENCIA ECONÓMICA DE UNA AGENCIA DE CRÉDITO PARA EL HOSPITAL O SU REPRESENTATE. FIRMA DEL PACIENTE O PARTE RESPONSABLE FECHA

Favor de incluir evidencia de las ganancias por cada ingreso actual de cada miembro de la familia de los últimos 3 (tres) meses. Esto incluye copia, talones de cheques, confirmación de sueldo del empleador, W2, impuestos de ingresos, cartas del Seguro Social, cartas del seguro por incapacidad, y cartas de miembros de la familia documentando el apoyo económico que proveen.