Southern Inyo Healthcare District
501 E. Locust Street
P.O. Box 1009
Lone Pine, CA 93545
Main Number: (760)876-5501
Fax: (760)876-4388

FINANCIAL ASSISTANCE APPLICATION

Date: _____

Dear: _____,

Southern Inyo Hospital uses this application to allow patients to apply for Full or Partial Charity Care and Financial Assistance (55% - 90%)

The following check list may be used to ensure you have supplied the required information necessary for your application to be considered for Financial Assistance, full or partial Charity Care.

_____ Prior year income tax return as submitted to IRS or
_____ Current period paycheck stubs; Unemployment or Disability payment stubs (2 months' worth)
_____ If you have no income or proof of income documents, please provide a letter explaining how you support yourself/your family.

Application received without proof of family income (tax returns or check stubs) cannot be processed. For questions, please contact the business office at (760) 876-5501. Completed applications and required documents should be returned to Southern Inyo Hospital Business Office via email: kgarcia@sihd.org or mailed to P.O. BOX 1009 LONE PINE, CA 93545.

Please complete this entire application to be considered under the Financial Assistance and Charity Care Program. List the total number of dependents, including yourself, at your address. **Incomplete applications cannot be processed.**

2025 Poverty Guidelines

(all states except Alaska and Hawaii)

Family/Household Size	Poverty Guideline	400% of Federal Poverty Line
1	$15,650	$62,600
2	$21,150	$84,600
3	$26,650	$106,600
4	$32,150	$128,600
5	$37,650	$150,600
6	$43,150	$172,600
7	$48,650	$194,600
8	$54,150	$216,600

*For families/households with more than 8 persons,
add $5,500 for each additional person to the poverty guideline.

If you think you may be eligible for uncompensated services, please complete and return the attached application for "Determination of Eligibility" and substantiating documentation of income and Medi-Cal or S.M.S.P. Share of Cost denial notice, if applicable, to the Southern Inyo Hospital Billing Office.

A written determination of your eligibility to receive uncompensated service will be made within 14 working days following the completion and submission of the "Determination of Eligibility" form substantiating documentation of income.

SOUTHERN INYO HEALTHCARE DISTRICT
FINANCIAL ASSISTANCE APPLICATION

Patient Information:

PATIENT NAME: _____ **SPOUSE:** _____
ADDRESS: _____ **PHONE:** _____
_____

PATIENT ACCT _____
FAMILY STATUS: List of all dependents that you support

Name	Age	Relationship
_____	_____	_____
_____	_____	_____

(add any additional family members on separate page) **Total Family members:** _____

EMPLOYMENT INFORMATION

Employer: _____ Position: _____
Supervisor/Contact Person: _____ Phone #: _____
If Self Employed – Name of Business: _____

Spouse Employer: _____ Position: _____
Supervisor/Contact Person: _____ Phone #: _____
If Self Employed – Name of Business: _____

CURRENT MONTHLY INCOME:

		Patient	Spouse
	Gross Pay (before deductions)	_____	_____
Add:	Income from Operating Business (self employed)	_____	_____
Add:	Other Income:	_____	_____
Equals:	Current Monthly Income	_____	_____
	Total Current Monthly Income (add patient+spouse Income from above)	_____	

I certify that the above information is true and accurate to the best of my knowledge. Further, I will apply for any assistance (Medi-Cal, Medicare, Insurance etc) which may be available for payment of my medical charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay the hospital the amount recovered for medical charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

I declare or affirm that the statements above are true and correct to the best of my knowledge and belief. I understand that withholding information or giving false information will make the patient and/or responsible party liable for payment of all charges for services rendered.

_____
Signature of Patient or Guarantor Date

_____
Signature of Spouse Date

ELIGIBILITY DETERMINATION **(For Office Use Only)**

Date Application Received: _____ Income Verified? Yes ___ No

Type of Verification:

_____
_____
_____

Medi-Cal Share of Cost? Yes ___ No ___ If yes, Amount: $

Financial Counselors' Notes:

_____ APPROVED FOR FULL CHARITY CARE _____ APPROVED FOR PARTIAL CHARITY CARE

_____ APPROVED FOR FINANCIAL ASSISTANCE DISCOUNT; _____ DISCOUNT PERCENTAGE

_____ NOT APPROVED

DECISION RATIONALE:
_____

VALID FROM:_____ THRU: _____
(A new application will be required after this date)

Date of Determination: _____

Approved by: _____