VENTURA COUNTY
HEALTH CARE AGENCY

Setting the Standard in Health Care Excellence

Ventura County Health Care Agency (HCA)

Discount Payment Program (DPP) Application

Applies to: Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) hospital billed services
Policy Reference: 110.032 – Discount Payment Program Policy
Effective Date:

The Ventura County Health Care Agency (HCA) is committed to providing the highest quality healthcare and emergency services to members of our diverse community. Our mission is to provide excellent comprehensive, cost-effective, compassionate healthcare throughout Ventura County.

At the HCA, we strive to make health care available to everyone in our community, regardless of their ability to pay. Our programs include a Discount Payment Program (DPP) for patients at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), Eastman Physical Therapy, and clinics licensed under VCMC. The DPP has six pay discount levels based on individual or family income. You can request financial assistance if your household income is at or below 400% of the Federal Poverty Level (FPL). Payment plans are also available for families with incomes above 400% of PFL. *(Please note that for patients in our Federally Qualified Health Centers (FQHC's), there is a separate application for out Sliding Fee Discount Program).*

PROGRAM AVAILABILITY LOCATIONS MARKED WITH •

Program Number	% of the Federal Poverty Level	Discount Program at non-FQHC Clinics	Discount Program at VCMC & SPH Hospitals
1	0% to 100%	•	•
2	100.01% to 138%	•	•
3	138.01% to 150%	•	•
4	150.01% to 200%	•	•
5	200.01% to 400%	•	•
6	greater than 400%	•	•

PURPOSE OF THIS APPLICATION

The Ventura County Health Care Agency (HCA) offers a Discount Payment Program (DPP) to assist patients who are unable to pay the full cost of medically necessary services provided at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), including hospital-based outpatient departments and clinics billed as hospital services.

This application does not apply to services provided in Federally Qualified Health Centers (FQHCs) or to clinics billed under a clinic fee schedule.

Submitting this application allows HCA to review your eligibility for:

- The **Discount Payment Program**, or
- **Charity Care**, if the review determines your expected payment would be $0.

WHO MAY APPLY

You may apply if:

- You do not have health insurance (self pay), or
- You have insurance but have high medical costs; and
- Your household income is at or below 400% of the Federal Poverty Level (FPL).

Immigration or citizenship status is not required to apply.

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PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Medical Record / Account Number (if known): _____

Address: _____

City / State / ZIP: _____

Phone: _____ Email (optional): _____

Responsible Party (If Different from Patient)

Name: _____

Relationship to Patient: _____

Address: _____

City / State / ZIP: _____

Phone: _____ Email (optional): _____

HOUSEHOLD INFORMATION

Please list all members of your household.

Family & Household Members	
First and Last Name	Relationship

INCOME INFORMATION

Please provide your total household income.

You may submit **one** of the following (no other documentation is required):

- Recent pay stubs (within the last 6 months), or
- A recent federal income tax return (current year or prior 12 months)

Household income amount: $_____ per ☐ month ☐ year

Important: HCA does **not** consider bank accounts, property, savings, or other assets when determining eligibility.

If you have no income, please explain: _____

_____

INSURANCE INFORMATION (IF APPLICABLE)

☐ I do not have health insurance.

☐ I have health insurance:

- Insurance name: _____
- Member ID (if known): _____

Applying for insurance (such as Medi-Cal or Covered California) **does not prevent** you from qualifying for the Discount Payment Program.

HIGH MEDICAL COSTS (IF APPLICABLE)

If you are insured or underinsured and believe you have high medical costs, please check the box below:

☐ I have out-of-pocket medical costs that exceed 10% of my household income. Please check all that apply:

☐ Copays / Deductibles / Coinsurance

☐ Other out-of-pocket hospital costs

(Documentation of medical expenses may be requested if needed to complete the review.)

(Optional) You may attach bills or explain here: _____

_____

PAYMENT PLANS

If approved for the Discount Payment Program, you may be eligible for an **interest free payment plan**. Payment plans are based on your discounted balance and ability to pay.

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AUTHORIZATION AND ACKNOWLEDGEMENT

Please read and sign below.

I certify that the information provided in this application is true and correct to the best of my knowledge. I understand that:

- This application is used to determine eligibility for hospital financial assistance;
- Eligibility is based on income and applicable law;
- Submitting this application does **not** guarantee approval;
- If approved, the type of assistance (Discount Payment Program or Charity Care) will be determined using standardized criteria;
- HCA may contact me if more information is needed; and
- Providing false information may result in denial of assistance.

I authorize HCA to verify the information provided **only as permitted by law**.

Applicant Signature: _____

Date: _____

HOW TO SUBMIT THIS APPLICATION

Please return this application with required income documentation by:

- Mail or In Person: 5851 Thille Street, Ventura, CA 93003
- Email: VCHCA.PatientAssistance@venturacounty.gov

If you need help completing this application or need language assistance, please contact:

Ventura County Health Care Agency – Patient Financial Services

Phone: 8056489553

Email: VCHCA.PatientAssistance@ventura.org

Website: https://hca.venturacounty.gov/help-paying-your-bill/

Free language assistance and interpreter services are available upon request.

If you disagree with the determination, you may request a review.