CHARITY CARE PROGRAM APPLICATION

The Ventura County Health Care Agency (VCHCA) 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.

The VCHCA hospitals, Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), and hospital clinics offer a Charity Care Program for hospital, ambulatory care and urgent care services to patients who meet the eligibility and asset tests described below, pursuant to Health & Safety Code sections 127400 through 127446.

Charity Care Program

PROGRAM AVAILABILITY LOCATIONS MARKED WITH ●

Program Number	% of the Federal Poverty Level	Charity Care Program at FQHC Clinics	Charity Care Program at Non-FQHC Clinics	Charity Care Program at VCMC & SPH
1	0% to 100%	NOT AVAILABLE	●	●
2	100.01% to 138%	NOT AVAILABLE	●	●
3	138.01% to 150%	NOT AVAILABLE	●	●
4	150.01% to 200%	NOT AVAILABLE	●	●
5	200.01% to 400%	NOT AVAILABLE	●	●
6	greater than 400%	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE

Who is Eligible:

- The patient does not have third party coverage from a health insurer, health care service plan, Medicare or Medi-Cal as determined and documented by the VCHCA; or
- The patient has incurred annual out-of-pocket medical costs at the hospital that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months, or annual out-of-pocket medical expenses that exceed 10 percent of the patient's family income; and
- The patient's injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by VCHCA; and
- The patient's family income does not exceed 400% of the Federal Poverty Level; and
- The patient has monetary assets of less than $10,000.00 Monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans (the patient's first $10,000 of monetary assets, and 50 percent of the patient's monetary assets in excess of $10,000, shall not be considered in determining eligibility).

To Apply Please Submit Documents Below:

- Proof of income such as a W-2 form, paycheck stub or tax return.
- Personal/family bank and credit card account information (if any).
- Estimate of household income and living expenses.
- Current medical bill information (if available).
- Identification (driver's license, identification card, or passport).

If you need assistance with our Charity Care Program policy requirements and/or the application, our staff will be happy to assist you. We provide Bilingual and Interpretation Services.

Our commitment to value the diversity of all persons and to be respectful and inclusive of everyone is facilitated by engaging and educating our community, to improve the overall health of everyone in our County. We at Ventura County Health Care Agency look forward in serving you.

Charity Care Application

Applicant/Patient Name: _____ _____ Date:_____ Account (if available) _____

First *Last*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Phone: _____ Email _____

Date of Birth: _____ Social Security or Individual Tax ID:_____

Month/Day/Year

Patient Employer: _____

Guarantor/
Person Responsible for Payment: _____

First *Last*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Phone: _____

Family Members

First and Last Name	Relationship

Income Information

Forms of Income:	Monthly Total for the Last 12 Months
Wages Total	$
If applicable Other Wages Total Related to Work: Strike Benefits Unemployment Military Allotment	$
If applicable Retirement Related Income: Social Security Pensions IRA	$
Other (if any): Alimony/Child Support Dividends/Interest Disability Trust Account Interest Income Other	$

Check Proof of Income Attached: W-2 Form ☐ Pay Check Stub ☐ Tax Return ☐

Bank Account Information (if any)

Bank Name/Branch	Type of Account (Checking, Savings, Primary)	Account Number
		$
		$
		$
Vehicles	**Year**	**$**
Homes	**Address**	**$**

Disclaimer and Signature

I the applicant/patient consent/agree/understand that my physician may be informed of this application for uncompensated care.

I the applicant/patient understand that I may be asked to prove my statements on this application and that my eligibility is subject to verification by VHCA by contacting my employer, bank and credit card companies for verification, and on-line property searches.

By submitting a Charity Care Program Application and as provided by federal law, I the applicant/patient, request that VCHCA determine my eligibility for uncompensated services, and understand if the information I provided is determined to be false, VCHCA will deny program eligibility and deny providing services as uncompensated services, and I the applicant/patient will be liable for charges for services provided.

I affirm that the statements made herein are true and correct to the best of my knowledge.

Applicant's Signature: _____ Date: _____

OFFICE USE ONLY SECTION

_____ _____
HCA Date

_____ _____
Print Witness Name Date