Patient Name:
Patient Address:

Patient Number:
Date (s) of Service:

CATALINA ISLAND HEALTH
An affiliate of UCI Health

Financial Assistance Evaluation Application

Thank you for choosing Catalina Island Health as your healthcare provider. Based upon our financial screening, you require financial assistance to pay for your visit.

Patients whose income is at or below 400% of the federal poverty level will be eligible for some kind of assistance. We are including our financial assistance/charity care application for your review. While the Hospital uses a single financial assistance application for both Charity Care and Discount Payment programs, patients are advised that Charity Care may provide a greater level of financial assistance than Discount Payment, depending on eligibility. Patients are encouraged to apply for all forms of financial assistance for which they may be eligible.

To determine your eligibility for financial assistance, please complete this enclosed application and provide copies of the following list of documents to our office as soon as possible. You are financially responsible for the outstanding balance until your application is reviewed and approved or denied.

☐ Recent paystubs
OR
☐ Recent tax return
☐ Proof of high medical cost (see below for explanation)
☐ Other: _____

<u>If your balance represents what you owe after your insurance has paid,</u> you may be requested to provide proof of high medical costs. High medical costs means annual out-of-pocket costs incurred by the individual **that exceed the lesser of 10 percent of the patient's current family income or** family income in the prior 12 months.

If you have any questions or need assistance completing our financial assistance application, please contact our Business Office at (310)510-0700 X112 from 8:30 a.m. to 4:00 p.m. Monday-Friday.

You may submit your completed application and documents to the hospital front desk 24 hours a day, 7 days a week. To mail the application and documents, please send to:

Catalina Island Health
P.O. Box 1563
Avalon, CA 90704

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaint.hcai.ca.gov for more information and to file a complaint.

Patient Name:
Patient Address:

Patient Number:
Date (s) of Service:

Help Paying Your Bill

There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to www.healthconsumer.org for more information.

The Catalina Island Health's Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs who are low-income, uninsured, or underinsured, ineligible for a government program, or are otherwise unable to pay for medically necessary care based on their individual family financial situation.

To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your timely cooperation will allow us to review your application and quickly determine your eligibility for financial assistance. Please complete the questionnaire below and return it with copies of your recent pay stubs or recent tax return.

Patient name:_____

Catalina Island Health Account # _____

Your name(s) and address (including country):

Phone numbers (circle best daytime number)

Home: _____ Your work: _____

Your spouse's work: _____

Date(s) of birth: Yours: Your spouse's/guarantor:

_____

Your employer or business (name and address)/Your spouse's employer or business (name and address):

_____

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Patient Name:
Patient Address:

Patient Number:
Date (s) of Service:

Age and relationship of people who live with you and are claimed on your tax returns (dependents only):

_____

MONTHLY/ANNUAL INCOME

Please provide photocopies of recent paystubs or return tax return and listed income.

Wages	Monthly	Annual
Self		
Spouse		
Other Family Members		
Other Income		
Total Income		

- I declare the answers I have given are true and correct to the best of my knowledge.
- I agree to tell the provider of services, within 10 days, if there are any changes in my (or my family's) income, expenses, or in the persons in the household or of any change of addresses.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the hospital from proceeds from any litigation or settlement resulting from such act.
- I understand that if I do not qualify for uncompensated services, I will be responsible for charges related to services received, and eligible for payment arrangements. I may appeal the charity determination decision in writing with additional documentation.

Signature_____ Date _____

Patient/Guarantor_____ Date _____