KVHD Kern Valley Healthcare District

Where Healthcare and Community Connect

Charity Care & Financial Assistance Policy – Plain Language Summary

Financial Assistance Offered

Kern Valley Healthcare District (KVHD) offers charity care and financial assistance through its Charity Care and Financial Assistance Policy to patients who are uninsured, underinsured, or who are unable to pay their hospital bills due to financial hardship. Our Financial Counselor will review individual cases and make a determination of financial assistance that may be offered prior to, during, or after services are provided. Upon verifying eligibility for financial assistance, KVHD shall offer hospital inpatients and outpatients discounted care in accordance with the KVHD Financial Assistance Policy for Medically Necessary Services.

Charity Care and Financial Assistance Guidelines

- Charity Care and Financial Assistance is available for emergency medical care and medically necessary care provided by Kern Valley Healthcare District.
- Eligibility is determined after reviewing an applicant's financial circumstances as discussed below.
- Eligibility for Charity Care and Financial Assistance will be based on family size and income.

Required Documentation

To be considered, a submitted application must include the following:

- Completed and signed financial assistance application
- Two recent pay stubs or most current W2
- Two months' bank statements

If an individual has no source of income, a letter stating how you financially meet your daily needs. If someone is financially assisting you with your daily needs, please have them write a statement stating that they are providing this assistance and how they are doing so.

Program Qualifications

- Charity Care will be given to an uninsured individual or a family whose yearly gross income does not exceed 400% of the federal poverty level.
- Underinsured patients, such as those with high-deductible consumer-driven health plans, are eligible to apply. To be eligible, applicants must incur out–of–pocket costs that exceed 10 percent of their gross family income in the prior 12 months.
- An individual who qualifies for financial assistance will not be required to pay more than the amounts indicated within the Financial Assistance Policy.

Accessing/Applying for Financial Assistance

- Copies of these documents are available at all KVHD's registration sites.
- All documents are free of charge
- To obtain copies of these documents in person or by mail, ask questions, receive assistance with completing the application, or submit a completed application, contact KVHD's Financial Counselor through the following methods:
    1. Phone: 760-379-2681 ext. 512
    2. In person: 6412 Laurel Ave., Lake Isabella, CA 93240
    3. By mail: P.O. Box 1628, Lake Isabella, CA 93240

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Charity Care and Financial Assistance Program

Kern Valley Healthcare District has a Patient Financial Assistance Program that may be of some assistance to you in paying your bill. Enclosed you will find a Financial Assistance Application to complete. You will need attach financial information in order for us to complete our review of your application for our Financial Assistance Program. You will continue to be billed and responsible for **all** Clinic/Hospital charges until this information is received. **The information must be provided for all members of the household**

Please complete the Financial Assistance Application and return with proof of income for all members of the household. It is important to complete the Financial Statement in its entirety. Please read and answer every question asked. If the question does not apply to you, write "N/A" for not applicable. If your answer is none please write "none" so we know you have considered the question. For proof of income, you will need the following:

- 2 recent pay stubs or your most current W2
- 2 months current bank statements

If you have no income you will need to provide a statement as to how you financially meet your daily needs. If someone is financially assisting you with your daily needs, please have them write a statement stating that they are providing assistance and how they are doing so.

Please return the financial assistance application along with your supporting documentation to the Financial Counselor immediately. You can do this by bringing it to our facility or by mailing it to:
KVHD
ATTN: Financial Counselor
PO Box 1628
Lake Isabella, CA 93240

If I can be of any assistance or you have any questions, please do not hesitate to contact me at the number listed below. I'm in the office from 8:00-4:30 Monday thru Friday.

Thank you,
Marine Lembeck
Financial Counselor
760-379-2681 ext. 512

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CHARITY CARE AND FINANCIAL ASSISTANCE APPLICATION

All information must be complete for consideration for financial assistance. If not applicable please indicate.

Patient Information

Name: _____

Address: _____

City/St/Zip: _____

Employer: _____

Employer Phone: _____

Monthly Income: _____

Spouse/Parent/Guarantor Information

Name: _____

Address: _____

City/St/Zip: _____

Employer: _____

Employer Phone: _____

Monthly Income: _____

Number of Dependents: _____ Names: _____, _____, _____, _____

List all other income: Source_____$_____ Source_____$_____

If unemployed what is your source of income? _____
(This must be answered if source of income is zero)

Do you have a checking account? Yes No Current Balance $_____
Do you have a savings account? Yes No Current Balance $_____

You must provide financial documentation in order for the this application to be processed

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

Signature: _____ Date: _____

The amount of discount is determined based on income level and Federal Poverty Guidelines.
Please note that not all physician professional fees are covered under the Financial Assistance Program.
For questions or assistance please call 760-379-2681 ext.512

Hospital Use Only: Circle One

Approved Charity Care Approved Sliding Scale Denied

Staff Representative Signature: _____ Date: _____

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