CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE
FINANCE DEPARTMENT

TITLE:	Patient Financial Assistance – Discounted Care and Charity Care Policy
Formulated:	6/87
Reviewed:	
Revised:	8/90, 8/91, 4/97, 9/97, 7/98, 5/01, 2/03, 6/05, 1/07, 2/11, 6/11, 5/13, 6/13, 9/13, 12/14, 3/16, 5/18, 11/18, 2/19, 8/19, 11/19, 2/20, 11/21, 1/22, 5/24

POLICY:

Casa Colina, Inc. and its affiliated corporations (referred to collectively as Casa Colina) strive to provide quality services in a caring environment and to make a positive measurable difference in the health of individuals we serve. Helping to meet the needs of the low-income, uninsured and underinsured patients is an important element of our commitment to the community. Casa Colina's financial assistance policy provides the means for the organization to demonstrate its commitment to achieving its mission and values.

The criteria Casa Colina will follow in qualifying patients for programs for financial assistance purposes are provided in this policy. The financial assistance policy has been developed in written form to effectively communicate how our commitment will be consistently administered to all parties. Patients who receive necessary services at Casa Colina and who do not have third party insurance coverage for their entire bill and who have difficulty paying their Casa Colina health services bills because of financial hardship are covered under the terms of the financial assistance policy.

Casa Colina recognizes the importance to create a charitable service policy that considers the needs of its community while balancing its long-term fiduciary responsibility. In the long run, sustainability of the organization remains essential to maintaining programs and services for the community. Casa Colina shall make available such amounts (budgeted annually) for financial assistance to patients.

This policy separates and differentiates between Discounted Care and Charity Care.

DEFINITION:

DISCOUNTED CARE is defined as services provided to patients who are either uninsured with higher income levels or are underinsured but whose income is at or below four hundred percent (400%) of the federal poverty level standard.

CHARITY CARE is defined as services customarily provided by Casa Colina, which are provided to patients who do not have available resources to pay and meet the federal poverty level. The services are provided either free or at nominal prices.

Charity Care or Discounted Care will not include administrative adjustments or contractual adjustments. Charity Care and Discounted Care shall be based on Federal Poverty Level (FPL), as well as other appropriate guidelines. The FPL guidelines are established and published in the Federal Register each calendar year (usually February) and adjust for family size.

Discounted Care

A. To qualify for a discounted payment a patient must meet the following criteria:

1. A patient's family income is at or below 400% of the Federal Poverty Level ("FPL").

2. A patient who is uninsured is a patient who does not have third-party coverage from a health insurer, healthcare service plan, Medicare, Medi-Cal, Regional Center and whose injury is not eligible for compensation under worker's compensation, automobile insurance, or other insurance as determined and documented by Casa Colina's Financial Services Department.

3. A patient who is insured but has "high medical costs" and who is at or below 400% of the Federal Poverty Level (FPL). A patient with high medical costs is defined as: a person whose family income does not exceed 400 percent of the federal poverty level and that individual does not receive a discounted rate from the hospital as a result of his or her third-party coverage. For these purposes, "high medical costs" means any of the following:

   a. Annual out-of-pocket medical expenses incurred by the individual 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, whichever is less. Or
   b. Annual out-of-pocket medical expenses that exceeded 10 percent of the patient's current family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

4. A patient must meet the income and asset tests as determined by California statute. Such tests are based on the "patient's family income" in that in defining a patient with high medical costs, a comparison of the patient's out-of-pocket expenses at Casa Colina to the "patient's family income," or a comparison of the patient's family income to medical expenses "paid by the patient or the patient's family."

   a. For persons 18 years of age and older, the patient's spouse, domestic partner, and dependent children per IRS guidelines, whether living at home or not.
   b. For persons under 18 years old, a parent, caretaker relatives, and other dependent children of the parent or caretaker relative.

5. A patient who receives a discount as a result of his/her third-party coverage may not be eligible for additional discounting of their remaining liability. If the patient's liability is based on a contractually discounted rate between Casa Colina and the insurer, the remaining patient liability may not be eligible for additional discounting.

6. Patient eligibility is determined based solely on the family's income; assets such as primary residence are not considered in the eligibility criteria.

7. Any patient who does not reasonably comply with Casa Colina's application process may be excluded from eligibility.

8. The patient's eligibility may be determined anytime Casa Colina is in receipt of documentation of income and expenses.

B. Casa Colina is required to notify uninsured, underinsured, and low-income patients of the availability of discounted and charity care programs. The process for notification shall consist of two types: (1) Written (Exhibit G) and 2) Public notice (Exhibit F)

1. Written Notice

The written notice shall include the following:

a. The availability of discounted/charity care that is based on a family's current income or family's income in the prior 12 months, whichever is less, in conjunction with the federal poverty guidelines as well as the availability of state and federal applications for medical coverage and eligibility information in both English and Spanish.
b. If it is determined that the patient's primary language is other than English or Spanish, and that language comprises greater than 5% of the facility's population, Casa Colina will provide the necessary information in the patients primary language.
c. The written notice will be published online at: www.casacolina.org/financialassistance. The Financial Assistance Policy Plain Language Summary (Exhibit D) will also be available at this web address.

2. Public Notice

The notices shall be posted in areas, which are clearly and conspicuously visible to the public. Such areas (check-in, registration, admissions office, billing office and other outpatient areas, including observation units) shall include, but are not limited to: Inpatient Services, Children's Services, Specialty Clinics, Imaging Center, and other outpatient settings such as Laboratory, Wound Care, and Radiology.

C. The application process for Discounted Care is as follows:

1. Admissions, Registration, and Patient Financial Services personnel will accept requests for consideration for discounted care. In addition, program manager/director and or other appropriate Casa Colina personnel, such as case managers and patient accounting representatives may accept requests for discounted care.

2. The patient, family, or financially responsible party shall complete the Application for Financial Assistance (see Exhibit A & B) and return it to the Patient Financial Services Department.

3. Financial assistance will be granted based on a completed application, including the related required documents. The discounted care eligibility of the patient is identified below. Eligibility for discounted care will be determined by a thorough financial screening process. Data collected includes:

a. Completed and signed financial assistance application;
b. Award letters for Social Security, SSI, Disability, Unemployment, General Relief, Alimony, etc.;
c. Family income from all sources:
    i. Most recent tax returns
    ii. Two most recent pay stubs;
d. Employment status, both current and future; or, if self- employed, current year-to-date profit and loss statement to determine current income;
e. Family size;
f. Last two months' bank, brokerage, and investment statements;
g. Copies of prior year's 1099 for interest income, dividends, capital gains, etc.;
h. Other appropriate financial data if tax returns or pay stubs are not available. Certain patient's assets, such as retirement plans, homes, and automobiles owned by the patient, are excluded.
i. Rent verification
j. Property/mortgage verification

4. Failure by the patient/client to provide adequate and complete information to substantiate the necessity for discount/charity care may result in the application being denied.

5. The initiator of the request will review the application for completeness and they will complete the Financial Assistance Request Form (Exhibit C). The completed request will then be returned to the Director of Patient Financial Services.

6. Casa Colina may accept deposits from a patient prior to the determination of discounted care. Should a deposit be made, Casa Colina shall refund such appropriate funds in a timely manner, including appropriate interest thereupon.

7. The Director of Patient Financial Services will complete the financial worksheet and compare the data to established poverty level guidelines (see Exhibit E).

8. The Director of Patient Financial Services will recommend approval or rejection of the submitted application and forward qualifying requests to the Chief Financial Officer for approval or rejection.

9. The Chief Financial Officer will forward the approved application to the Chief Planning and Development Officer and the Chief Executive Officer for final approval or rejection.

10. If all levels of approval are given, the Director of Patient Financial Services will inform the patient or designated representative of such approval. The original application is maintained in Patient Financial Services Department for the period of 10 years or as required by current regulations. In the event that the application for financial assistance is denied, the requesting party will be notified in writing. Approvals and denials will be supported by reasonable documentation supporting such decisions as outlined in the federal poverty guidelines (FPL). All decisions will be communicated in writing to the requestor no later than 14 business days from final approval or denial date.

11. The patient may contact the Director of Patient Financial Services or designee in the event of a dispute of our determination.

12. A patient may appeal a denial. The Director of Patient Financial Services shall review all the financial data along with the application on file. The patient may submit additional information, including, but not limited to updated financial data and/or other relevant information to substantiate the request for financial assistance.

13. Patients are eligible for a re-evaluation under the financial screening procedure:

    a. At the time of each inpatient/outpatient admission.
    b. When any relevant data previously considered has changed, such as income, family size, special or unusual expenses, and so on.
    c. After one year elapses from the completion of their last financial screening.

14. The Finance Department will maintain a log of all approved Discounted Care and Charity Care adjustments.

D. The billing and collection process in regard to discounted care is identified as follows:

1. For patients who have not provided adequate proof of insurance, the Patient Financial Services department shall provide information in summary form along with appropriate contact information regarding the Patient Financial Assistance Policy. The information Casa Colina shall provide is as follows:

    a. A statement of charges for services rendered by Casa Colina.
    b. A request that the patient inform the patient financial services department if the patient has health insurance coverage, Medicare, Healthy Families, Medi-Cal, or other coverage.
    c. Medicare patients seeking financial assistance for a copayment, co-insurance, or deductible assigned by Medicare are candidates for Medicare Bad Debt after 180 days from the first bill date and after reasonable collection efforts were made by Patient Accounting and a Debt Collection Agency to collect the debt. These balances are not considered Charity Care.
    d. A statement indicating that a patient may obtain an application for Medi-Cal, California Health Benefit Exchange (Covered California), and CCS.
    e. Information about the “Financial Assistance Application” including:

        i. A statement that indicates that if the patient lacks, or has inadequate, insurance and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care.
        ii. Reasonable efforts to obtain a patient's third party health coverage information, including coverage through the California Health Benefits Exchange will be made. The hospital will notify the patient that they may be eligible for health coverage through the California Benefit Exchange, or other state- or county-funded health coverage.

2. Should a patient qualify for partially discounted care, the remaining balance due will be collected using the standards and practices of Casa Colina for billing and collections. External collection agencies utilized by Casa Colina shall also adhere to Casa Colina standards and practices. All debt collection practices will include all appropriate fair debt language. The standards and practices are as follows:

    a. Prior to the debt being advanced to a collection agency, Patient Financial Services shall make reasonable efforts to inform the patient/client of the status of their financial obligation. That includes but is not limited to:

        i. An initial itemization of charges incurred.
        ii. Three monthly billing statements. The third and final notice will be sent no less than 120 days from determining the balance is patient responsibility.
        iii. A telephone call will be placed after 30 days from the bill date to collect payment in full or negotiate a payment arrangement if no response to previous statement(s) has been received.

    b. Any debt assigned to a collection agency must have met the above criteria and the assignment date must be greater than 180 days from initial billing. The exception to the above would be any account that is deemed to be uncollectible due to inaccurate address (returned mail with no forwarding address, phone, or bankruptcy).
    c. Neither Casa Colina nor a collection agency may use wage garnishments or file liens on assets except if court ordered.
    d. A patient may request an extended payment arrangement to satisfy the remaining debt once the discount has been applied. Such extension should be based on the circumstances of each patient with a standard installment of up to 6 months and must be approved by the Director of Patient Financial Services. If Casa Colina and the patient cannot agree on repayment plan terms, default monthly payments will consist of an amount not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses as defined in California Health and Safety Code Section 127400(i).
    e. No interest may be charged during the payment period. Should the patient fail to make payment for ninety days (90) days or fail to renegotiate the payment plan, Casa Colina will take immediate action and assign unpaid debt for immediate collections.

<u>Charity Care</u>

A. For a patient to qualify for charity care they must meet the following criteria:

    1. A patient is at or below 400% of the Federal Poverty Level ("FPL").

    2. If a patient's family income is 200% or less of the FPL, then entire amount of the bill will be forgiven.

    3. If a patient's family income is between 201% and 400% of the FPL, then a portion of bill is forgiven based on a sliding scale as follows:

a. 201% to 250% = 75 % forgiven
b. 251% to 300% = 50% forgiven
c. 301% to 400% = 25% forgiven

4. If a patient's family income is more than 400% of the FPL, the patient will not automatically qualify for charity care adjustment based on the income level. However, financial assistance may be considered when the specific circumstances of care were created by a catastrophic medical condition or event.

5. Casa Colina shall request and verify the same personal financial information as required for Discounted Care above. In assessing the patient/clients monetary assets, the first $10,000 of a patient's monetary assets and 50% of assets above $10,000 will not be considered in determining eligibility.

OTHER ELIGIBLE CIRCUMSTANCES:

Casa Colina deems those patients that are eligible for any or all government sponsored low-income assistance programs to be indigent. Therefore, such patients are automatically eligible for Charity Care under the Casa Colina Policy and account balances will be classified as Charity Care if the government program does not make payment for all services provided, or days during a hospital stay.

For example, patients who qualify for Medi-Cal, CCS, CHDP, MSI, CMSP, or other similar low-income government programs are eligible for financial assistance.

Any or all non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any other failure to pay for covered or non-covered services provided to Medi-Cal and/or other government low-income qualified patients are covered.

Patients with restricted coverage and/or other forms of limitation shall have non-covered amounts classified as Charity Care when payment is not made by the low-income government program.

The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as Charity Care if:

1. The patient is a beneficiary under Medi-Cal or another program serving the healthcare needs of low-income patients; or
2. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

Any patient who experiences a catastrophic medical event may be deemed eligible for financial assistance. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $100,000 may be considered for eligibility as a catastrophic medical event.

Any account returned to the hospital from a collection agency, where it has been determined the patient or guarantor does not have the resources to pay their bill, may be deemed eligible for Charity Care. Documentation of the patient or guarantor's inability to pay for services will be maintained in the Charity Care documentation file.

OTHER HELPFUL RESOURCES

In addition to the information contained in the application process, patients may receive additional education and guidance regarding the billing and payment process from the Health Consumer Alliance. They can be reached at: https://healthconsumer.org.

Casa Colina also provides a listing and estimated charges for its shoppable services. This listing can be found at the following web address: https://www.casacolina.org/patients-families/hospital-charges

CRITERIA FOR RE-ASSIGNMENT FROM BAD DEBT TO CHARITY CARE

All outside collection agencies contracted with Casa Colina to perform account follow-up and/or bad debt collection will utilize the following criteria to identify a status change from bad debt to Charity Care:

1. Patient accounts must have no applicable insurance coverage including governmental or other third party payers);
2. The patient or guarantor must have an Experian credit score rating of less than or equal to 500. If the collection agency is using a credit scoring tool other than Experian, the patient and or guarantor must fall into 20th percentile of credit scores for the method used;
3. The patient or guarantor has not made a payment within one hundred eighty (180) days of assignment to the collection agency;
4. The collection agency has determined that the patient/guarantor is unable to pay;
5. The patient does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score; and
6. Medicare patients assigned to an outside collection agency after 180 days from the first statement and unable to pay or has not paid for a copayment, co-insurance, or deductible assigned by Medicare are candidates for Medicare Bad Debt. The outside agency has to exhaust collection efforts outlined by the hospital provider and return the account as Medicare Bad Debt to the Hospital after 45 days of reasonable collection efforts. Accounts are returned as Medicare Bad Debt. These balances are not considered Charity Care.

ATTACHMENT(S):

Exhibit A – Financial Assistance Application *(English)* (attached within P&P) *(Reviewed 11/18/21, 1/2022, 5/2024)*

Exhibit B – Financial Assistance Application *(Spanish)* (attached within P&P) *(Reviewed 11/18/21, 1/2022, 5/2024)*

Exhibit C – Financial Assistance Request Form (attached within P&P) *(Reviewed 11/18/21, 1/2022, 5/2024)*

Exhibit D – Financial Assistance Policy Plain Language Summary (attached within P&P) *(Formulated 11/18/21; Revised 1/2022, 5/2024)*

Exhibit E – Financial Worksheet and 2024 Federal Poverty Guidelines (attached within P&P) *(Revised 1/2024)*

Exhibit F – Public Notice of the Availability of Discount/Charity Care Programs *(English & Spanish)* (attached within P&P) *(Reviewed 11/18/21, 1/2022, 5/2024)*

Exhibit G – Written Notice of the Availability of Discount/Charity Care Programs *(English & Spanish)* (attached within P&P) *(Reviewed 11/18/21, 1/2022, 5/2024)*

Exhibit H – Covered California Fact Sheet *(English & Spanish)* (attached within P&P) *(Reviewed 11/18/21, 1/2022, 5/2024)*

Exhibit I – County of Los Angeles DHCS List of Local Programs *(English)* (attached within P&P) *(Reviewed 11/18/21, 1/2022, 5/2024)*

CASA COLINA
Hospital and Centers for Healthcare

Requested By: _____

Financial Assistance Application

Date: _____

Patient /Guarantor Name: _____

Address:

_____

_____

Please complete and provide all requested information to the best of your abilities in order for Casa Colina Hospital and Centers for Healthcare to accurately determine if you qualify for our Financial Assistance Program, which is based on Federal Poverty Guidelines.

- ✓ Completed and signed Financial Assistance Application
- ✓ Award letters for Social Security, SSI, Disability, Unemployment, General Relief, Alimony, etc.
- ✓ Most recent tax returns
- ✓ Pay stubs (most recent available)
- ✓ Employment status, both current and future; or, if self-employed, current year-to-date profit and loss statement to determine current income
- ✓ Family size
- ✓ Last two months' bank, brokerage and investment statements
- ✓ Copies of prior year's 1099 for interest income, dividends, capital gains, etc.
- ✓ Other appropriate financial data if tax returns or pay stubs are not available. Certain assets—such as retirement plans, homes, and automobiles owned by the patient—are excluded.
- ✓ Rent verification
- ✓ Property/mortgage verification

Please note that any incomplete application will be denied and sent back to you for completion and/or supporting documentation. If you have any questions, please contact our **Patient Financial Services Department** at **909/596-7733, ext. 5558**. Faxed requests can be faxed to **909/450-0141.**

Enclosure: [ ] Application: [ ]

For Casa Colina Internal Purposes Use Only

Please complete the below information prior to providing the application to the applicant. For questions or clarification, please contact the **Director of Patient Financial Services** at ext. 5558.

Department:	
Team Number:	
Date Application was given to the Applicant:	
Internal Requestor:	

Financial Assistance Application

Patient's Name: _____ Phone: (_____) _____

Address: _____ Date of Birth: _____

_____ Sex: ☐ Female ☐ Male

Social Security No: _____

SECTION 1: FAMILY INFORMATION

List all persons living in the household who are related by birth, marriage, and/or adoption. Include related college students who do not reside with family but are supported by the family.

Name	Date of Birth	Sex	Relationship	Social Security No.

SECTION 2: GROSS MONTHLY INCOME

List all employers for each member of household and attach proof of gross income (before taxes or deductions). Examples of proof of income: income tax return or check stub(s), profit/loss statement from accountant (for self-employed persons).

Name	Employer Name, Address, & Phone Number	Monthly Income

List all other income including social security, railroad retirement, unemployment compensation, worker's compensation, welfare/AFDC, supplemental security income, alimony, child support, military allotment, support from an absent family member or someone not living in the household, private or government pensions, insurance or annuity payments, income from dividends, interest, rents, royalties, and/or estates/trusts. Please attach proof of income.

Source of Income	Monthly Income

SECTION 3: MONTHLY INCOME

Briefly describe your employment status including date of hire and/or last date of employment/retirement. If you are receiving income from other sources, describe the type of support, the date support began, and the date the support is expected to end, if applicable. Also, describe any other pertinent details about your income.

Identify ALL sources of monthly income for your household. Enter the person receiving the income and the amount received each month for each income category that is applicable. In addition to completing this application, for each type of income that you identify below, submit the required documentation listed AND your most recently filed tax return including ALL supporting schedules, two months of bank statements, savings account statements, and brokerage/investment statements.

OCCUPATION:	Required Documentation	Patient or Applicant	Spouse/Other Family
Wages	2 current pay stubs		
Hourly rate			
Average monthly hours worked			
Self-employment gross receipts	YTD P&L Schedule (1)		
Partnership income	YTD P&L Schedule (1)		
Social Security	Award		
Supplemental Security Income (SSI)	Award		
Unemployment	Award		
Disability	Award		
Workers compensation	Award		
General relief	Award		
Temporary Assistance for Needy Families (TANF)	Award		
Food stamps/Electronic Benefit Transfer (EBT)	Award		
Alimony	Award		
Child support	Award		
Student loans	Award		
Pension/Annuities	Last year's 1099		
Interest income	Last year's 1099		
Dividends	Last year's 1099		
Capital gains	Last year's 1099		
Gross rental income			
Other:			
TOTAL MONTHLY INCOME			

(1) YTD P&L Statement means the current year-to-date profit & loss statement for the business/partnership. If your family does not have income, in the space below, please describe how you have been able to meet your needs for food and shelter. If another person has been providing support, in addition to the below, please ask the person to send Casa Colina Hospital and Centers for Healthcare a letter describing the type of support, frequency, and duration of the support.

SECTION 4: MONTHLY EXPENSES	Patient or Applicant	Spouse/Other Family
Mortgage of owner-occupied residence		
Mortgage of rental property		
Rent		
Property taxes		
Car payment		
Childcare		
Cell phone		
Food & household supplies		
Car insurance & gas		
Clothing		
Medical & dental expenses		
Insurance		
Credit card payments		
Tuition		
Child support		
Spousal support		
Installment payments		
Laundry & cleaning expenses		
Other:		
TOTAL MONTHLY EXPENSES		

If the reported monthly expenses exceed reported income, explain how you are able to meet these financial obligations.

_____

_____

_____

Please state if the patient has applied for Medi-Cal or any other government programs. If yes, please provide information below:

Program Name:

_____

ID/Policy #: _____

Date of Program:

_____

Other: _____

SECTION 5: OTHER

Are you employed? ☐ Yes ☐ No Will you be employed in the future? ☐ Yes ☐ No

Have you filed bankruptcy? ☐ Yes ☐ No If so, when?

Also, please include any further information you feel might be helpful or make any statement you believe would assist us in reviewing your application.

_____

_____

_____

PURPOSE: The purpose of this information is to determine your ability to pay for services at Casa Colina Hospital and Centers for Healthcare or your possible eligibility for a medical assistance program. This information is NOT an application for Medi-Cal, County Medically Indigent Services Program, California Children Services, Healthy Families, or any other county assistance program.

YOU MUST CONTACT THE DEPARTMENT OF SOCIAL SERVICES IN YOUR COUNTY OF RESIDENCE TO APPLY FOR ASSISTANCE PROGRAMS.

I certify the above information to be accurate and complete, and that this application is made for Casa Colina and Centers for Healthcare to determine my eligibility for discounted or charity care. I understand that Casa Colina Hospital and Centers for Healthcare reserves the right to verify all information supplied, including permission to contact employers and to check my/our credit history. I agree to notify the Patient Accounting Department of any change in my financial information within 10 days of the change.

I UNDERSTAND THAT I MAY BE STILL RESPONSIBLE FOR THE FULL AMOUNT OF MY CHARGES AT CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE.

Signature of Patient/Responsible Party: _____

Printed Name: _____ Date: _____

Signature of Casa Colina Hospital and Centers for Healthcare Representative: _____

Printed Name: _____ Date: _____

CASA COLINA
Hospital and Centers for Healthcare

Solicitado por: _____

Solicitud de ayuda económica

Fecha: _____

Nombre del paciente/garante: _____

Dirección: _____

_____

_____

Llene y brinde toda la información solicitada de la mejor manera posible para que Casa Colina Hospital and Centers for Healthcare pueda determinar con precisión si usted es apto para recibir nuestro Programa de ayuda económica, el cual se basa en las Pautas Federales de Pobreza.

- ✓ Solicitud de ayuda económica llenada y firmada
- ✓ Cartas de otorgamiento para el seguro social, SSI, discapacidad, desempleo, ayuda general, pensión alimenticia, etc.
- ✓ Declaraciones de impuestos más recientes
- ✓ Boletas de pago (las más recientes que tenga)
- ✓ Situación laboral, actual y futura; o, si es trabajador autónomo, declaración de ganancias y pérdidas actuales del año hasta la fecha para determinar el ingreso actual
- ✓ Tamaño de la familia
- ✓ Estados de cuenta bancaria, corretaje e inversiones de los dos últimos meses
- ✓ Copias del formulario 1099 del año calendario pasado con información sobre ingresos por intereses, dividendos, plusvalía, etc.
- ✓ Otros datos financieros pertinentes si no se cuenta con declaraciones de impuestos o boletas de pago. Se excluyen ciertos bienes del paciente, tales como planes de jubilación, casas y automóviles de propiedad del paciente.
- ✓ Verificación del alquiler (renta)
- ✓ Verificación de bienes inmuebles/hipoteca

Tenga en cuenta que cualquier solicitud incompleta será denegada y enviada de vuelta para ser llenada y/o para que se añadan documentos pertinentes. Si tiene preguntas, comuníquese con el **Departamento de Servicios Financieros para los Pacientes** al **909/596-7733, anexo 5558**. Las solicitudes se pueden enviar por fax al **909/450-0141.**

Documentos adjuntos: [ ] Solicitud: [ ]

Solo para usos con fines internos de Casa Colina Llene la información a continuación antes de entregar la solicitud del solicitante. Si tiene preguntas o dudas, contacte al **Director de Servicios Financieros para los Pacientes** en el anexo 5558.	
Departamento:	
Número de equipo:	
Fecha de entrega de la solicitud al solicitante:	
Solicitante interno:	

Solicitud de ayuda económica

Nombre del paciente: _____ Teléfono: (_____) _____

Dirección: _____ Fecha de nacimiento: _____

_____ Sexo: ☐ Femenino ☐ Masculino

Número de seguro social: _____

SECCIÓN 1: INFORMACIÓN FAMILIAR

Enumere a las personas que viven en su casa que tienen parentesco por nacimiento, matrimonio y/o adopción. Incluya a los estudiantes de la universidad que no viven con la familia pero que reciben apoyo económico.

Nombre	Fecha de nacimiento	Sexo	Relación	Número de seguro social

SECCIÓN 2: INGRESO BRUTO MENSUAL

Enumere a todos los empleadores de cada miembro del hogar y adjunte pruebas de ingreso bruto (antes de los impuestos o deducciones).

Ejemplos de prueba de ingreso: declaración de impuestos sobre la renta o boletas de pago, declaración de ganancias/pérdidas del contador (para los trabajadores autónomos).

Nombre	Nombre del empleador, dirección y teléfono	Ingreso mensual

Enumere todo otro ingreso tal como seguro social, pensión ferroviaria, subsidio de desempleo, indemnización por accidentes laborales, asistencia social/AFDC, ingreso de seguridad complementario, pensión alimenticia para el cónyuge, pensión alimenticia para los hijos, asignación militar, asistencia de un familiar ausente o alguien que no vive en su hogar, pensión privada o pública, pagos del seguro o renta vitalicia, ingresos de dividendos, intereses, alquileres, regalías y/o de bienes raíces o fideicomiso. Adjunte las pruebas de ingresos.

Fuentes de ingreso	Ingreso mensual

SECCIÓN 3: INGRESO MENSUAL

Describa brevemente su situación laboral e incluya la fecha de contratación y/o la última fecha de empleo/jubilación. Si recibe ingresos de otras fuentes, describe el tipo de asistencia, la fecha cuando comenzó y la fecha cuando se prevé que termine, si corresponde. También describa cualquier otro detalle pertinente de sus ingresos.

Identifique TODA fuente de ingreso mensual en su hogar. Enumere a las personas que reciben ingresos y la cantidad que reciben cada mes en cada categoría de ingresos que sea aplicable. Además de llenar esta solicitud, presente todos los documentos requeridos para cada tipo de ingresos que identifique a continuación E incluya la declaración de impuestos más reciente incluyendo TODOS los apéndices correspondientes, estados de cuenta bancaria de dos meses, estados de cuenta de ahorro y estados de cuenta de inversiones/corretaje.

OCUPACIÓN:	Documentos requeridos	Paciente o solicitante	Cónyuge/otro familiar
Salario	2 boletas de pago actuales		
Tarifa por hora			
Promedio de horas laborales mensuales			
Facturación bruta de trabajo autónomo	YTD P&L, Apéndice (1)		
Ingreso de sociedad colectiva	YTD P&L, Apéndice (1)		
Seguro social	Otorgamiento		
Ingreso de seguridad complementario (SSI)	Otorgamiento		
Desempleo	Otorgamiento		
Discapacidad	Otorgamiento		
Indemnización por accidentes laborales	Otorgamiento		
Ayuda general	Otorgamiento		
Asistencia Temporal para Familias Necesitadas (TANF)	Otorgamiento		
Cupones para Alimentos/Electronic Benefit Transfer (EBT)	Otorgamiento		
Pensión alimenticia para el cónyuge	Otorgamiento		
Pensión alimenticia para los hijos	Otorgamiento		
Préstamo estudiantil	Otorgamiento		
Pensión/renta vitalicia	1099 del año pasado		
Ingresos por intereses	1099 del año pasado		
Dividendos	1099 del año pasado		
Plusvalía	1099 del año pasado		
Ingreso bruto por alquiler			
Otros:			
INGRESO MENSUAL TOTAL			

(2) YTD P&L YTD, P&L significa la declaración de ganancias y pérdidas actuales del año hasta la fecha del negocio o sociedad colectiva. Si su familia no cuenta con ingresos, describa en el espacio a continuación cómo ha podido cubrir sus necesidades de alimento y vivienda. Si otra persona ha estado brindándole ayuda, además de lo que se indica a continuación, pídale a esa persona que envíe a Casa Colina Hospital and Centers for Healthcare una carta describiendo el tipo de ayuda, frecuencia y duración de la ayuda.

SECCIÓN 4: GASTOS MENSUALES	Paciente o solicitante	Cónyuge/otro familiar
Hipoteca de residencia ocupada por el dueño		
Hipoteca de propiedad en alquiler		
Alquiler (renta)		
Impuestos prediales (inmobiliarios)		
Pagos por automóvil		
Cuidado de niños		
Teléfono celular		
Alimentos y artículos para el hogar		
Seguro de automóviles y gasolina		
Ropa		
Gastos médicos y dentales		
Seguro		
Pago de tarjetas de crédito		
Pago (matrícula y clases) de estudios		
Pensión alimenticia para los hijos		
Pensión alimenticia para el cónyuge		
Pagos fraccionados		
Gastos de lavado de ropa y limpieza		
Otros:		
GASTOS MENSUALES TOTALES		

Si los gastos mensuales reportados exceden los ingresos reportados, explique cómo puede cumplir con estas obligaciones económicas.

_____

_____

_____

Indique si el paciente ha solicitado en ingreso en Medi-Cal o cualquier otro programa gubernamental. Si es así, brinde la información que figura a continuación:

Nombre del programa:

_____

N.° de póliza/identificación:

_____

Fecha del programa:

_____

Otros: _____

SECCIÓN 5: OTROS

¿Usted trabaja? ☐ Yes ☐ No ¿Trabajará en el futuro? ☐ Sí ☐ No

¿Se ha declarado en bancarrota? ☐ Sí ☐ No ¿Cuándo?

Incluya también cualquier información que considere útil o indique lo que crea importante que podría ayudarnos a evaluar su solicitud.

_____

_____

_____

OBJETIVO: El objetivo de esta información es determinar su capacidad para pagar los servicios de Casa Colina Hospital and Centers for Healthcare o su posible aptitud para recibir un programa de ayuda médica. Esta información NO es una solicitud para Medi-Cal, County Medically Indigent Services Program, California Children Services, Healthy Families ni ningún otro programa de ayuda en el condado.

DEBE CONTACTAR AL DEPARTAMENTO DE SERVICIOS SOCIALES DE SU CONDADO DE RESIDENCIA PARA SOLICITAR EL INGRESO EN PROGRAMAS DE AYUDA.

Certifico que la información anterior es precisa y completa y que estoy presentando esta solicitud a Casa Colina and Centers for Healthcare para determinar mi aptitud para recibir atención médica con descuento o atención benéfica. Comprendo que Casa Colina Hospital and Centers for Healthcare se reserva el derecho de verificar toda la información brindada, incluido el permiso para contactar a empleadores y verificar mis/nuestros antecedentes crediticios. Acepto notificar al Departamento de Contabilidad de esta entidad sobre cualquier cambio en mi información financiera en el plazo de 10 días del cambio.

COMPRENDO QUE YO PODRÍA SEGUIR SIENDO RESPONSABLE DEL MONTO COMPLETO DE LOS CARGOS EN CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE.

Firma del paciente/parte responsable: _____

Nombre en letra de imprenta: _____ Fecha: _____

Firma del representante de Casa Colina Hospital and Centers for Healthcare: _____

Nombre en letra de imprenta: _____ Fecha: _____

FINANCIAL ASSISTANCE REQUEST
CASA COLINA USE ONLY

Date: _____

[ ] Free Care / Via Foundation
(Do Not Qualify for Charity Care)

[ ] Charity Care / Uncompensated Care Request
(Per Federal Poverty Guideline in CCH policy)

[ ] Discounted Care

[ ] Medicare Bad Debt

[ ] Wounded Warrior

(Applicable only after 120 days of Medicare RA and collections efforts; Medicare balances do not qualify for Charity Care cost reporting.)

Team: _____Corporation: _____ Requested by: _____

Patient Name: _____

Social Security Number: _____
Diagnosis: _____

Requested Uncompensated Care: $ _____ = _____ days/visits (LOS)

Requested Discounted: $ _____

JUSTIFICATION:

ELIGIBILITY: _____Approved _____ Disapproved _____ Partial (_____%)

Eligible for $_____ , _____days/visits (LOS)

By: _____ Date: _____

Comments: _____

_____

AUTHORIZATION: _____ Approved _____ Disapproved _____ Partial (_____)

By: Chief Financial Officer _____ Date _____

_____ Approved _____ Disapproved
By: Chief Planning & Development Officer_____ Date _____

_____ Approved _____ Disapproved
By: President and CEO _____ Date _____

Casa Colina Hospital and Centers for Healthcare
Financial Assistance Policy Plain Language Summary

Who is eligible?
A patient may be eligible for discounted care if family income is at or below 400% of the Federal Poverty Level. Charity care is available if family income is at or below 200% of the Federal Poverty Level. If family income is between 201% and 400% of the Federal Poverty Level, then a portion of the bill may be forgiven.

What does the Financial Assistance Policy cover?
The Financial Assistance Policy covers medically necessary healthcare services provided at Casa Colina Hospital and Centers for Healthcare. Physician services are excluded from Casa Colina Hospital and Centers for Healthcare's Financial Assistance Policy.

How to apply:
To obtain our Financial Assistance Policy and Financial Assistance Application online, please visit www.casacolina.org/financialassistance. Paper copies are also available in the Admitting and Registration Departments throughout the facility located at 255 E. Bonita Ave., Pomona, CA 91767. If you would like a copy sent to you via U.S. mail, please call 909/596-7733, ext. 5558. The application is available in English and Spanish.

Once the application is complete, please return the application to any Casa Colina registration personnel or billing department personnel, or mail to P.O. Box 6001, Pomona, CA 91769-6001 or fax to 909/450-0141with all applicable documentation listed below.

- Completed and signed Financial Assistance Application
- Award letters for Social Security, Supplemental Security Income (SSI), Disability, Unemployment, General Relief, Alimony, etc.
- Family income from all sources (including tax returns)
- Pay stubs (most recent available)
- Employment status, both current and future; or, if self- employed, current year-to-date profit and loss statement to determine current income
- Family size
- Last two months' bank, brokerage, and investment statements
- Copies of last calendar year's 1099 for interest income, dividends, capital gains, etc.
- Other appropriate financial data if tax returns or pay stubs are not available. Certain patient's assets - such as retirement plans, homes, and automobiles owned by the patient - are excluded.
- Rent verification
- Property/mortgage verification

Failure to provide required documentation may delay the application process or cause your application to be denied. Complete application and documentation are necessary to determine eligibility. If you have questions or need assistance completing the application, please call 909/596-7733, ext. 5558.

FINANCIAL WORKSHEET AND
2024 FINANCIAL POVERTY GUIDELINES – CASA COLINA DISCOUNT PERCENTAGE

Persons In Household	Federal Poverty Guidelines		Between 100%		And 200%	
1	$15,060		$15,060		$30,120	
2	$20,440		$20,440		$40,880	
3	$25,820		$25,820		$51,640	DISCOUNT **100%**
4	$31,200		$31,200		$62,400	
5	$36,580		$36,580		$73,160	
6	$41,960		$41,960		$83,920	
7	$47,340		$47,340		$94,680	
8	$52,720		$52,720		$105,440	

Persons In Household	Federal Poverty Guidelines		Between 201%		And 250%	
1	$15,060		$30,122		$37,650	
2	$20,440		$40,882		$51,100	
3	$25,820		$51,643		$64,550	DISCOUNT **75%**
4	$31,200		$62,403		$78,000	
5	$36,580		$73,164		$91,450	
6	$41,960		$83,924		$104,900	
7	$47,340		$94,685		$118,350	
8	$52,720		$105,445		$131,800	

FINANCIAL WORKSHEET AND
2024 FINANCIAL POVERTY GUIDELINES – CASA COLINA DISCOUNT PERCENTAGE

Persons In Household	Federal Poverty Guidelines	Between 251%	And 300%	
1	$15,060	$37,652	$45,180	
2	$20,440	$51,102	$61,320	
3	$25,820	$64,553	$77,460	DISCOUNT **50%**
4	$31,200	$78,003	$93,600	
5	$36,580	$91,454	$109,740	
6	$41,960	$104,904	$125,880	
7	$47,340	$118,355	$142,020	
8	$52,720	$131,805	$158,160	

Persons In Household	Federal Poverty Guidelines	Between 301%	And 400%	
1	$15,060	$45,182	$60,240	
2	$20,440	$61,322	$81,760	
3	$25,820	$77,463	$103,280	DISCOUNT **25%**
4	$31,200	$93,603	$124,800	
5	$36,580	$109,744	$146,320	
6	$41,960	$125,884	$167,840	
7	$47,340	$142,025	$189,360	
8	$52,720	$158,165	$210,880	

* Federal Register, February 1, 2024. The above amounts are annual income.

Public Notice

If you are uninsured or underinsured, you may qualify for the Financial Assistance Program. Paper copies of the Financial Assistance Program are available upon request. Please contact the Admissions or Registration Departments or call the Patient Accounting Department at 909/596-7733, ext. 5558 or online at www.casacolina.org/financialassistance.

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Notificacion Publica

Si usted no tiene cobertura de seguro médico, podrá calificar para el Programa de Ayuda Económica. Las copias en papel del Programa de Ayuda Económica están a disposición de los interesados. Comuníquese con los Departamentos de Ingreso o Inscripción, llame al Departamento de Contabilidad al (909) 596-7733, ext. 5558 o visite la página web www.casacolina.org/financialassistance.

CASA COLINA
Hospital and Centers for Healthcare

Copy of the Conditions of Admission and Patient Handbook

Casa Colina Hospital and Centers for Healthcare is proud of its goal to provide quality care to all who need it regardless of ability to pay.

If you do not have health insurance and worry that you may not be able to pay in full for your care, we may be able to help. Casa Colina provides financial assistance to patients based on their income and needs. We may be able to help you get financial coverage or work with you to arrange a manageable payment plan.

It important that you let us know if you will have trouble paying your bill; federal and state laws require health organizations make reasonable efforts to collect payment for services from patients/clients. The organization may turn unpaid bills over to a collection agency, which could affect your credit status. We would like to work with you to avoid this situation.

For more information, please contact our Patient Accounting office at 909/596-7733, ext. 5558. We will treat your questions with confidentiality and courtesy.

Patient Name: _____ MR#: _____
Date of Birth: _____

NOTIFICACION PARA EL PACIENTE / CLIENTE SOBRE ASISTENCIA FINANCERIA

Casa Colina Hospital y Centros de Salud está orgulloso de su misión de proporcionar atención de calidad a todos los que necesitan independientemente de la capacidad de pago.

Si usted no tiene seguro médico y tiene preocupaciones que no puede pagar por su cuidado , o servicios, cabe la posibilidad que le podemos ayudar. Casa Colina Hospital y Centros de Salud proporciona ayuda financiera a los pacientes basados en sus ingresos y necesidades. Quizás puedamos ayudarle a conseguir la cobertura financiera, o trabajar con usted para organizar un plan de pagos manejable.

Es importante que usted nos haga saber si usted tendra dificultad en pagar su cuenta; las leyes federales y del estado requieren a organizaciones médicas que hagan esfuerzos razonables para recuperar fondos por servicios a pacientes/clientes. La organización puede mandar cuentas no pagadas a una agencia de colección, que puede afectar su estado de crédito. Quisieramos trabajar con usted para evitar esta situación.

Para mas información, por favor comuniquese con nuestra oficina de Servicios al Paciente a (909) 596-7733 ext. 5558. Trataremos sus preguntas en confianza y con cortesía.

Nombre de Paciente: _____ MR#: _____

Fecha de Nacimiento: _____

COVERED CALIFORNIA FACT SHEET (ENGLISH)

this way to health insurance.

A STEP-BY-STEP GUIDE

COVERED CALIFORNIA

we've got you covered.

Covered California was created to help Californians compare, afford and enroll in brand-name health insurance plans. Most people who enroll receive financial help, and everyone is guaranteed the same, high-quality coverage.

we're here to help.

For help at any point during the enrollment process, call 800.300.1506 or visit CoveredCA.com. We offer free, expert assistance online, in-person, and over the phone in 13 languages as well as for the hearing-impaired.

step one. see if you qualify for help paying for health coverage.

You could pay as little as $0/month for your plan, and you won't pay more than 8.5% of your income for our benchmark Silver plan. You may also qualify for low or no-cost Medi-Cal.

To estimate your monthly payment with our calculator tool, scan the QR code or visit CoveredCA.com/#quick-calculator

A STEP-BY-STEP GUIDE TO HEALTH INSURANCE.

step two. explore your coverage options.

Covered California offers four levels of coverage: Bronze, Silver, Gold and Platinum. Insurance companies pay a portion of covered services, and the benefits offered within each level are the same no matter which insurance company you choose.

Choose **Platinum** or **Gold** and you'll pay a higher monthly premium, but you'll pay less for medical services when you need them.

Choose **Silver** or **Bronze** and you'll pay a lower monthly premium, but you'll pay more for medical services when you need them.

A **minimum coverage plan** is available to those under 30, or those 30 and over who have received a hardship exemption from the U.S. Department of Health and Human Services.

Visit CoveredCA.com and choose "Shop and Compare" to see which brand-name health plans are right for you.

STANDARD COVERAGE BENEFITS BY LEVEL —

KEY BENEFITS	BRONZE Covers 60% of average annual cost	SILVER Covers 70% of average annual cost	GOLD Covers 80% of average annual cost	PLATINUM Covers 90% of average annual cost
Individual / family deductible	$6,300 / $12,600	$5,400 / $10,800**	No deductible	No deductible
Annual preventive care visit	No cost	No cost	No cost	No cost
Primary care visit copay	$60*	$50	$35	$15
Urgent care visit copay	$60*	$50	$35	$15
Emergency room copay	40%*	$450	$350	$150
Generic medication copay	$17	$19	$15	$7
Annual out-of-pocket max for one	$9,100 /year	$9,100 /year	$8,700 /year	$4,500 /year
Annual out-of-pocket max for family**	$18,200 /year	$18,200 year	$17,400 /year	$9,000 /year

Chart does not include all medical copays and coinsurance rates. For complete information, visit CoveredCA.com.
*For Bronze Plans, the deductible is waived for the first three primary care or urgent care visits. Additional visits are charged at full cost until deductible is met.
**Silver is the only level where your deductible and other costs may be lower based on your household income.
†40% after the deductible, up to annual out-of-pocket max.

COVERED CALIFORNIA

step three. what you need to enroll.

The following is needed for every household member who is applying for coverage:

- **Home ZIP code**
- **Birth date**
- **Proof of current household income***
- **California ID or driver's license**
- **Social Security number or Individual Taxpayer Identification Number, if you have one**
- **Proof of citizenship or lawful presence (e.g., U.S. passport, certificate of citizenship or naturalization document, green card, or a valid visa)****

AM I REQUIRED TO HAVE HEALTH INSURANCE?

In California, most people are required by law to have health insurance or pay a tax penalty: $850/adult + $425/child under 18, up to $2,550/household, or 2.5% of your annual household income over your California tax filing threshold, whichever is higher.

UNDERSTANDING HMOS, PPOS AND EPOS

Most insurance companies offer three types of plans:

"HMOs"

Health Maintenance Organizations only cover medical services inside the plan's network. HMOs often require members to get a referral from their primary care doctor to see a specialist.

"PPOs"

Preferred Provider Organizations pay for medical services both inside and outside the plan's network, but members pay a higher amount of the cost for out-of-network care. No referral is required to see a specialist.

"EPOs"

Exclusive Provider Organizations generally don't cover care outside the plan's network, but members may not need a referral to see an in-network specialist.

It's important to note that not all HMOs, PPOs and EPOs are the same. Before choosing a plan, use the Shop and Compare tool at CoveredCA.com to get details like what doctors and hospitals are covered and what it will cost to see a doctor out-of-network.

*Proof of current income of all members in the tax household, such as a recent tax return, W-2, or pay stub. A dependent's income should only be included if their income level requires them to file a tax return. A household is defined as the person who files taxes as the primary tax filer and all the dependents claimed on that person's taxes. If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal.
**You can apply for your eligible child or spouse even if you are not eligible.

Covered California complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.300.0213 (TTY: 1.888.889.4500).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1.800.300.1533 (TTY 1.888.889.4500).

YOUR PROTECTIONS THROUGH COVERED CALIFORNIA

As part of the Affordable Care Act (ACA), Covered California guarantees that —

- **Preexisting health conditions cannot prevent someone from being covered.**
- **Your plan cannot be canceled because you are sick or injured.**
- **All plans include free preventive care.**
- **Young adults can be covered under their parents' plan until the age of 26.**
- **All private information, including immigration/citizenship status, is kept confidential.**

step four. create an account and enroll.

Enroll in your plan at CoveredCA.com. Simply create a user account and follow the enrollment process with the information in step three.

step five. pay your premium.

Pay your monthly premium in full and on time to ensure that your coverage continues. Failing to pay your premium may disrupt or even cancel your health coverage.

OPEN ENROLLMENT IS

Nov 1 — Jan 31

Medi-Cal and Special Enrollment are available year-round. Special Enrollment allows Californians to get coverage within 60 days of a qualifying life event, such as losing health insurance, a change in household size, or moving to or within California.

For more information on Special Enrollment, visit CoveredCA.com/special-enrollment.

need help?

If you have questions or to find free, local, in-person help, contact:

CoveredCA.com | 800.300.1506

ENG-0723

COVERED CALIFORNIA FACT SHEET (SPANISH)

tu seguro médico empieza aquí.

UNA GUÍA PASO A PASO

COVERED CALIFORNIA

tenemos la cobertura que necesitas.

Covered California fue creado para ayudar a los californianos a comparar e inscribirse en planes de seguro médico de renombre asequibles. La mayoría de las personas que se inscriben reciben ayuda económica, y a todos se les garantiza la misma cobertura de alta calidad.

estamos aquí para ayudarte.

Si necesitas ayuda en cualquier punto del proceso de inscripción, llama al 800.300.0213 o visita CoveredCA.com/espanol. Te ofrecemos ayuda gratuita y experta en línea, en persona y por teléfono en 13 idiomas, así como para personas con impedimentos auditivos.

primer paso. entérate si calificas para recibir ayuda para pagar tu cobertura médica.

Podrías pagar desde $0 al mes por tu plan, y no pagarás más de 8.5% de tus ingresos con nuestro plan Silver estándar. También podrías calificar para recibir Medi-Cal sin costo alguno o por un costo mínimo.

Para calcular tu pago mensual con nuestra calculadora de costos, escanea el código QR o visita CoveredCA.com/espanol/#quick-calculator

UNA GUÍA PASO A PASO PARA TU SEGURO MÉDICO.

segundo paso. explora tus opciones de cobertura.

Covered California ofrece cuatro niveles de cobertura: Bronze, Silver, Gold y Platinum. Las compañías de seguro pagan una porción de los servicios cubiertos, y los beneficios que se ofrecen dentro de cada nivel de cobertura son los mismos sin importar qué compañía de seguro elijas.

Si eliges **Platinum** o **Gold** pagarás una cuota mensual más alta cada mes, pero pagarás menos por los servicios médicos cuando los necesites.

Si eliges **Silver** o **Bronze** pagarás una cuota mensual más baja cada mes, pero pagarás más por los servicios médicos cuando los necesites.

Existe un **plan de cobertura mínima** para las personas menores de 30 años, o para los de 30 años o mayores que hayan recibido una exención de dificultad económica del Departamento de Salud y Servicios Humanos de los Estados Unidos.

Visita CoveredCA.com/espanol y dale clic a "Buscar y Comparar" para ver qué planes de seguro médico de renombre son los mejores para ti.

BENEFICIOS ESTÁNDAR DE LA COBERTURA POR NIVEL –

BENEFICIOS CLAVE	BRONZE Cubre el 60% del costo promedio anual	SILVER Cubre el 70% del costo promedio anual	GOLD Cubre el 80% del costo promedio anual	PLATINUM Cubre el 90% del costo promedio anual
Deducible individual / familiar	$6,300 / $12,600	$5,400 / $10,800**	Sin deducible	Sin deducible
Visita anual de cuidado preventivo	Sin costo	Sin costo	Sin costo	Sin costo
Copago por visita de cuidado primario	$60*	$50	$35	$15
Copago por vista de cuidado de urgencia	$60*	$50	$35	$15
Copago de sala de emergencias	40%†	$450	$350	$150
Copago de medicamento genérico	$17	$19	$15	$7
Máximo de gastos de bolsillo para una persona	$9,100	$9,100	$8,700	$4,500
Máximo de gastos de bolsillo para una familia**	$18,200	$18,200	$17,400	$9,000

La tabla no incluye todos los copagos médicos ni cuotas de coseguro. Para ver la información completa, visita CoveredCA.com/espanol.
*Para los planes Bronze, no se paga el deducible de las primeras tres visitas con el médico primario o de cuidado urgente. Se cobra el costo completo de las visitas adicionales hasta cubrir el deducible.
**Silver es el único nivel de cobertura en donde tu deducible y otros costos pueden ser menores con base al ingreso de tu hogar.
†40% después del deducible, hasta el máximo gasto de bolsillo máximo.

COVERED CALIFORNIA

tercer paso. lo que necesitas para inscribirte.

Esto es lo que necesita cada miembro de tu hogar que esté solicitando cobertura:

- **Código postal de la casa**
- **Fecha de nacimiento**
- **Prueba actual de ingresos del hogar***
- **Identificación o licencia de manejo de California**
- **Número de seguro social o número de identificación para el pago de impuestos, si lo tienes**
- **Comprobante de ciudadanía o presencia legal (por ejemplo, pasaporte, certificado de ciudadanía o documento de naturalización, tarjeta de residencia ("green card") o una visa válida)****

¿ES OBLIGATORIO TENER SEGURO MÉDICO?

En California, la mayoría de las personas tienen la obligación legal de tener seguro médico o pagar una multa de impuestos: $850 por adulto + $425 por niño menor de 18 años, hasta $2,550 por hogar o 2.5% del ingreso anual de tu hogar que sobrepase el límite de declaración de impuestos de California, el que sea más alto.

QUÉ SON LOS HMO, PPO Y EPO

La mayoría de las compañías de seguros ofrecen tres tipos de planes:

"HMO"

Las Organizaciones para el Mantenimiento de la Salud solo cubren servicios médicos dentro de la red de proveedores del plan. Muchas veces, las HMO requieren que los miembros obtengan una aprobación de su médico primario para ver a un especialista.

"PPO"

Las Organizaciones de Proveedores Preferidos pagan por los servicios médicos realizados dentro y fuera de la red de proveedores del plan, pero los miembros pagan una cantidad más alta por el costo de servicios obtenidos fuera de la red. No se requiere ninguna aprobación para ver a un especialista.

"EPO"

Por lo general, las Organizaciones de Proveedores Exclusivos no cubren los servicios obtenidos fuera de la red de proveedores del plan, pero los miembros pueden no requerir de una aprobación para ver a un especialista dentro de la red.

Es importante resaltar que no todos los planes de HMO, PPO y EPO son iguales. Antes de elegir un plan, usa la herramienta de Buscar y Comparar en CoveredCA.com/espanol para ver los detalles, como los hospitales y doctores que están cubiertos y lo que costará ver a un doctor fuera de la red.

* Comprobante de ingresos de todos los miembros del hogar, por ejemplo, una declaración de impuestos reciente, W-2 o talón de pago. El ingreso de un dependiente solo debe incluirse si su nivel de ingresos requiere que presente una declaración de impuestos. Un hogar se define como la persona que declara impuestos como el contribuyente principal y todos los dependientes identificados en la declaración de impuestos de esa persona. Incluso si tú no declaras impuestos, puedes calificar para recibir un seguro gratuito o de bajo costo a través de Medi-Cal.
** Puedes solicitar cobertura para tu hijo o cónyuge que cumpla con los requisitos incluso si tú no calificas.

Covered California complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.300.0213 (TTY: 1.888.889.4500).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1.800.300.1533 (TTY 1.888.889.4500).

QUÉ PROTECCIONES TIENES CON COVERED CALIFORNIA

Como parte de la Ley de Cuidado de Salud a Bajo Precio (ACA, por sus siglas en inglés), Covered California garantiza que —

- **Tener una condición de salud preexistente no puede evitar que alguien obtenga cobertura.**
- **Tu plan no puede ser cancelado porque estás enfermo o lesionado.**
- **Todos los planes incluyen cuidado preventivo gratuito.**
- **Los adultos jóvenes pueden estar cubiertos por el plan de sus padres hasta los 26 años de edad.**
- **Toda la información privada, incluyendo el estatus migratorio/de ciudadanía, se mantiene como confidencial.**

cuarto paso. crea una cuenta e inscríbete.

Inscríbete en tu plan en CoveredCA.com/espanol. Simplemente crea una cuenta de usuario y sigue el proceso de inscripción con la información del tercer paso.

quinto paso. paga tu cuota.

Paga tu cuota mensual en su totalidad y a tiempo para asegurar que tu cobertura continúe. No pagar la cuota puede interrumpir e incluso cancelar tu cobertura de salud.

EL PERIODO DE INSCRIPCIÓN ABIERTA ES

desde el 1 de noviembre hasta el 31 de enero

Medi-Cal y la inscripción especial están disponibles todo el año. La inscripción especial permite que los californianos obtengan cobertura dentro de los 60 días después de un evento calificado de vida, como haber perdido el seguro médico, un cambio en el número de personas en el hogar o haberse mudado a California o dentro del estado.

Para más información sobre la inscripción especial, visita CoveredCA.com/espanol/special-enrollment.

¿necesitas ayuda?

Si tienes preguntas o para obtener ayuda gratuita en persona cerca de ti, contáctanos en:

CoveredCA.com/espanol | 800.300.0213

SPA-0723

COUNTY OF LOS ANGELES DHCS LIST OF LOCAL PROGRAMS (ENGLISH)

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

YOU CAN GET NO-COST OR LOW-COST MEDICAL CARE

AT ANY LA COUNTY CLINIC OR HOSPITAL IF YOU ARE ELIGIBLE FOR ONE OF THE PROGRAMS BELOW

Program	Who Can Get it?	How Much Does It Cost?	What Care Is Covered?	Where Do I Go for Care?
Ability to Pay (ATP) *The former ORSA is now part of ATP*	Los Angeles County residents who do not qualify for Medi-Cal, or Medicare	• No-Cost for persons with incomes at or under 138% FPL • Low-Cost for those over 138% FPL	• Clinic and outpatient hospital visits • Tests and medicines • Inpatient hospital care • Emergency Room (ER) visits • Certain surgeries	ONLY • County hospitals • County clinics
Pre-Payment Plan	Los Angeles County residents	• A low-cost, flat fee for each visit.	• Clinic and outpatient hospital visits • Tests only • ER visits • Certain outpatient surgeries *Does not include hospital inpatient care or medicine you take home*	ONLY • County hospitals • County clinics
Discount Payment Plan	Non-County residents who • have no insurance or have high medical costs even with insurance • do not qualify for Medi-Cal; income is at or under 400% FPL	• A 5% discount off charges or what Medi-Cal would pay (whichever is less)	• Inpatient hospital care and outpatient hospital visits • Emergency Room (ER) visits	ONLY • County hospitals
Specialty No-Cost or Low-Cost Programs				
County Mental Health Services (Short Doyle)	Persons needing mental health treatment who • Do not qualify for Medi-Cal • Are functionally disabled by severe and persistent mental illness or who are seriously emotionally disturbed	• One amount for the whole year • Varies, depending on family size, resources and income	• Inpatient hospital care • Outpatient mental health care	• Call the L.A. County Department of Mental Health at 800-854-7771 to find a county mental health facility
Child Delivery Plan	• Pregnant women who are Los Angeles County residents • Each mother must apply for Medi-Cal for her baby	• $2,000 flat fee paid within 7 days after leaving the hospital	• All labor and delivery services	ONLY • County hospitals
Dialysis; TB; Post-Polio	• Dialysis & Post-Polio: California residents • TB: No residency requirement	• Low-Cost fees	• Care for kidney disease, inpatient tuberculosis care, and post-polio related services	ONLY • County hospitals • County clinics

Who Can Apply for No-Cost or Low-Cost programs in LA County?

Minimum requirements	Patients must be a Los Angeles County resident and provide acceptable proof that you live in Los Angeles County (ID and proof of address or statement certifying homelessness) and must have medical costs that Medi-Cal, Medicare, private insurance or other benefits won't pay.
What is income at 138% of the Federal Poverty Level (FPL)?	Income is based on your family size. **For 2022, 138% FPL monthly income is $1,564 for a family of one; $2,106 for two; $2,650 for three; $3,192 for four; $3,735 for five; $4,278 for six; $4,821 for seven; $5363 for eight; $5,907 for nine; $6,449 for ten.** For families larger than ten, add about **$544** per person. For pregnant women count the woman and the number of expected babies. A county worker will see if your income qualifies for these programs and the amount you must pay.
Can non-LA County residents still receive low-cost care?	**Yes, non-LA County residents may receive a discount on their cost for care at LA County hospital under the Discount Payment Plan if they have income at or under 400% FPL.** *Only LA County residents may get no-cost medical care.*

HS000026 **(04-22)** Page **1** of **2**

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

Additional information about No-Cost or Low-Cost programs in LA County

How to apply for ATP	**ATP:** Patients apply for ATP during a financial screening appointment at one of the hospitals and clinics listed below. The amount you must pay, if anything is based on your income. The application is good for one year.
What are payments for ATP?	ATP covers inpatient and outpatient care with one agreement. • Patients whose incomes are above 138% FPL pay a low-cost for services. • Patients pay **one amount** for each inpatient admission, regardless of how long the patient stays in the hospital. • Patients only pay one amount **each month** for outpatient care, regardless of how many outpatient visits the patient has in a month. • General Relief patients always get care at no-cost.
Can I use ATP for services not covered by other programs?	**Yes** - You may use ATP for services not covered by Medi-Cal, Medicare or private insurance. • ATP will cover your deductible for private insurance, but it doesn't cover Medicare deductibles or Medi-Cal share of cost.
Can I get more time for payments?	**Yes** – If you are in the ATP or Out-of-County programs and cannot pay the amount you owe within 30 days, you may make arrangements to pay it over a longer period of time. Our extended payment plan determines how long you have to pay based on your income, resources and family size.
Do I have to apply for Medi-Cal before I get a County No Cost/Low-Cost Program?	**Yes** - If a County worker determines that you may qualify for Medi-Cal. Also, new mothers using the Child Delivery Plan must apply for Medi-Cal for their baby. *If you do not fully cooperate with the Medi-Cal application process, you cannot get ATP, Discount Payment or Child Delivery Plan.* **No** - If using Pre-Payment, you do not have to apply for Medi-Cal. Pregnant women who use the Child Delivery Plan do not have to apply for Medi-Cal.
Are Prescriptions covered by ATP?	**Yes** - Prescriptions are covered by ATP and there is no extra cost to you if you have a certain type of coverage, i.e., Fee for Service Medi-Cal.
Pre-Payment Amounts	$60 for prenatal visits for the first 7 visits, the rest are at no-cost; Comprehensive Health Centers (CHC) and Health Centers (HC); hospital clinics, MLK Outpatient Center, & High Desert Regional HC $80 for urgent care visits at all locations; $60 for clinic visits at $140 at county hospital emergency rooms; $80 for clinic visits at county $500 at outpatient surgery clinics.
Is my immigration status affected by using these programs?	The County does **NOT** report patients to US Citizenship and Immigration Services. US Citizenship and Immigration Services will **Not** consider you a public charge if you use the No-Cost or Low-Cost Programs.

For more information and where to apply, go to http://dhs.lacounty.gov - see below for list of L.A. County locations

Harbor/UCLA Medical Center 1000 W. Carson St. Bldg. 3-South, Torrance 90509 (424) 306-7000	**LAC+USC Medical Center** 2051 Marengo St., Los Angeles 90033 (323) 409-6361	**Olive View/UCLA Medical Center** 14445 Olive View Dr., Rm.1D138, Sylmar 91342 (747) 210-3082		**Rancho Los Amigos National Rehab. Center** 7601 E Imperial Hwy Bldg SSB, Ste 1011, Downey 90242 (562) 385-7320
Antelope Valley Health Center 335-B E. Ave. K-6 Lancaster 93535 (661) 471-4147	East San Gabriel Health Center 1359 N. Grand Ave., Covina 91724 (626) 877-0012	La Puente Health Center 15930 Central Ave., La Puente 91744 (626) 986-2900	San Fernando Health Center 1212 Pico St., San Fernando 91340 (818) 627-4777	H Claude Hudson Comp. Health Center. 2829 South Grand Ave., Los Angeles 90007 (213) 699-7000
Bellflower Health Center 10005 E. Flower St., Bellflower 90706 (562) 526-3000	El Monte Comp. Health Center 10953 Ramona Boulevard El Monte 91731 (626) 434-2500	Littlerock Community Clinic 8201 Pearblossom Hwy., Littlerock 93543 (661) 471-4147	South Valley Health Center 38350 40th St. East, Palmdale 93550 (661) 471-4147	H.H. Humphrey Comp. Health Center 5850 So. Main St., Los Angeles 90003 (323) 897-6000
Curtis R. Tucker Health Center 123 W. Manchester Blvd., Inglewood 90301 (310) 419-5325	E. R. Roybal Comp. Health Center 245 S. Fetterly Ave., Los Angeles 90022 (323) 362-1010	Long Beach Comp. Health Center 1333 Chestnut Ave., Long Beach 90813 (562) 753-2300	Torrance Health Center 711 Del Amo Blvd., Torrance 90502 (310) 354-2300	High Desert Regional Health Center 335 East Ave I, Lancaster 93535 (661) 471-4147
Bell HC 6901 S Atlantic Ave., Bell 90201 (323) 897-6000	Glendale Health Center 501 N. Glendale Ave. Glendale 91206 (818) 291-8900	Mid Valley Comp. Health Center 7515 Van Nuys Blvd. Van Nuys 91405 (818) 627-3000	West Valley Health Center 20151 Nordhoff Street Chatsworth 91311 (818) 407-3100	Martin Luther King, Jr. Outpatient Center 1670 East 120th St. Los Angeles 90059 (424) 338-1817
East Los Angeles Health Center 133 N. Sunol Drive, Suite150 Los Angeles 90063 (323) 768-2500	Lake Los Angeles Clinic 16921 E. Avenue 0, Space G Lake Los Angeles 93591 (661) 471-4000	Northeast Health Center 3303 North Broadway, Ste. 200 Los Angeles 90031 (323) 362-1717	Wilmington Health Center 1325 Broad Ave. Wilmington 90744 (310) 404-2040	