BHC Alhambra Hospital
Application for Discount or Charity
Solicitud de descuento o beneficencia

It is the policy of BHC Alhambra Hospital, in compliance with California State law AB774 (Hospital Fair Pricing Policies), to provide discounts from standard billed charges for all self pay and high medical cost patients as defined above. To determine if you are eligible for discount or charity, please complete the following information (the business office staff will assist in completion of the form if requested).

Es política de BHC Alhambra Hospital, según la ley estatal AB774 de California (Políticas de fijación de precios justos para hospitales), proporcionar descuentos en gastos estándares facturados para todos los pacientes que pagan por cuenta propia y pacientes con costos médicos elevados según se define a continuación. Para determinar si usted es elegible para un descuento o beneficencia, complete la siguiente información (el personal de la oficina comercial lo ayudará a completar el formulario si fuese necesario):

Patient Name (Nombre del paciente): ___________________________________

Patient account # (Número de cuenta del paciente): _________________________

Guarantor Name (Nombre del garante): __________________________________

Annual income (Ingreso annual): $ ________________

(*Note:* annual income must be supported by either a current pay stub or your most recent income tax return).

(*Nota:* el ingreso anual debe estar acompañado de un recibo de sueldo o su declaración de impuesto sobre las rentas más reciente).

Number of persons in family or household (Cantidad de personas de la familia o en la casa): _________

Out-of-pocket medical expenses during the previous 12 months (including an estimate of your out of pocket costs for this hospitalization) (Gastos médicos en efectivo durante los 12 meses anteriores (incluido un estimado de sus costos en efectivo para esta hospitalización)): ________________

Total monetary assets (excluding retirement or deferred compensation plans) (Total de activos monetarios (sin incluir los planes de retiro o de compensación diferida)): $ _____________

For completion by business office staff only.

1. Annual income ________________
2. Federal Poverty Level (FPL) for family size ________________
3. Line 1 as a percent of line 2 ________________
4. Maximum payable by Medicare or Medi-Cal for stay ________________
5. Total monetary assets ________________

Insured patients only:

1. Expected out of pocket cost for this stay ________________
2. Total out of pocket expenses-previous 12 months ________________
3. Line 6 plus line 7 as a percent of line 1 ________________

Discount for self-pay patients to be applied to the stay based on the following grid:

Line 3 percent	Required discount	Approved discount
Greater than 350%	0%	
251% to 350%	Higher of Medicare or Medi-Cal payment for stay	
101% to 250%	50% of the higher of Medicare or Medi-Cal payment for stay	
Up to 100% and line 5 less than $10,000	100%	
Up to 100% and line 5 greater than $10,000	0%. Total payment may not exceed amount of line 5 greater than $10,000.	

Discount for insured patients to be applied to the stay based on the following grid:

Line 3 percent	Required discount	Approved discount
Greater than 350%	0%	
Less than 350% and line 8 is greater than or equal to 10%	Total payment received from insurance plus patient will not exceed 100% of the higher of Medicare or Medi-Cal payment	

Federal Poverty Guideline as of 1/1/24:

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$ 15,060	$18,810	$17,310
2	20,440	25,540	23,500
3	25,820	32,270	29,690
4	31,200	39,000	35,880
5	36,580	45,730	42,070
6	41,960	52,460	48,260
7	47,340	59,190	54,450
8	52,720	65,920	60,640
For each additional person, add	5,380	6,730	6,190