Tri-City Medical Center

Financial Assistance Application Form

Financial Assistance (Charity Care) is available to you if you don't have the resources to pay your hospital expenses and don't qualify for any government programs. Any uninsured patient who indicates an inability to pay will be screened for charity care. Additionally, at the discretion of the Hospital, any insured patient who indicates an inability to pay their liability after their insurance has paid will be screened for charity care. If you need assistance in completing the form please (760) 940-5912.

Instructions for Completing the Application for Financial Assistance:

Financial Assistance Qualifications: All application funding sources must be complied with and determined prior such as Medi-Cal and other state or county programs. Your financial assistance application may be pended if you have applied for another health coverage program at the same time until the outcome for that application has been determined.
Patients who have no third-party source of payment, such as an insurance company or government program, for any portion of their medical expenses **and** have a family income at or below 400% of the federal poverty level.
Patients who are covered by insurance but have (i) family income at or below 400% of the federal poverty level; **and** (ii) medical expenses for themselves or their family (incurred at the hospital affiliate or paid to other providers in the past 12 months) that exceed 10% of the patient's family income.
Patients who are covered by insurance but exhaust their benefits either before or during their stay at the hospital, and have a family income at or below 400% of the federal poverty level.

Proof of Income Required:

Along with your application, please attach the following information or an explanation as to why this information is not available. Missing documentation may delay the process of your application and could result in a denial for financial assistance.
Current employer's six (6) months of recent pay stubs or other statements of income for all family members
Tax Return Form (1040) for current year.

Once completed, the application and supporting documents can be submitted to any registration team member, cashier, or patient financial services team.

Financial Assistance Notification Process:
Once the eligibility process is complete you will receive a financial assistance notification letter in the mail. The form will indicate if you are eligible for full or Discounted Payment Program. You may receive a notification that you are ineligible for financial assistance or that more information is needed to decide e.g., determination.

Sincerely,
Tri-City Medical Center - Financial Assistance Team

Tri-City Medical Center

Financial Assistance Application Form

Application Date: _____

Patient Information

Patient Name (Last, First)	Date of Birth:
Street Address	Phone Number:
City, State, Zip Code	Medical Record or Account Number

Spouse or Parent/Guardian (if patient is less than 18 years old) Information

Name (Last, First)	Date of Birth:
Street Address (if not same as patient)	Phone Number:
City, State, Zip Code	Relationship to Patient:

Parent Information (if patient is less than 18 years old)

Name (Last, First)	Date of Birth:
Street Address (if not same as patient)	Phone Number:
City, State, Zip Code	Relationship to Patient:

Additional Questions (Please circle Yes or No)

1. Was the patient a resident of California at the time of service?	Yes	No
2. Did the patient have medical insurance at the time of service?	Yes	No
3. Was the patient an active Medicaid recipient at the time of service?	Yes	No
4. Were your injuries caused by a third party (such as during a car accident or slip and fall?)	Yes	No
5. Do you have other insurance that may apply (such as an auto policy)?	Yes	No
*If you answered **Yes** to questions 2 or 5, please attach a copy of your insurance or Medicaid card to this application.		

Family Household/Dependents (List the number of family members who live in your home)

Name	Relationship to Patient	Age

Tri-City Medical Center

Monthly Gross Income (List ALL adult Income from family members in the household)

Monthly Gross (Before Taxes) Income Sources	Patient	Family Members
Employment/Self Employment	$	$
Social Security	$	$
Disability	$	$
Unemployment	$	$
Pension, Retirement, Annuity	$	$
Alimony/Child Support	$	$
Other	$	$
Total Combined Monthly Income: $		
If you do not have monthly income, please attach a written statement explaining how you or the patient are taking care of your monthly expenses including who provides food, shelter, transportation, etc. and how long you have been without income.		

SIGNATURE

My signature below certified that everything I have stated on this application is correct and subject to review under audit. I understand that if the information I provide is determined to be false, financial assistance may be denied and I may be responsible to pay for services provided.

Applicant's Name **Applicant's Signature** **Date**

Please send your completed application and required documents to:

Tri-City Medical Center
Patient Accounting
4002 Vista Way Oceanside, CA 92056
760-940-7329

Tri-City Medical Center

2025 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty Guidelines (100%)	Poverty Guidelines (400%)
1	$0 - $15,650	$62,600
2	$0 - $21,150	$84,600
3	$0 - $26,650	$106,600
4	$0 - $32,150	$128,600
5	$0 - $37,650	$150,600
6	$0 - $43,150	$172,600
7	$0 - $48,650	$194,600
8	$0 - $54,150	$216,600
For families/households with more than 8 persons, add $6,880 for each additional person.		