BARSTOW COMMUNITY HOSPITAL

Hospital Discounted Payment and Charity Care Application

Please fill out all information completely. If it does not apply, write N/A.

Date of Application: _____

This Is An Application For:		
□ Discounted Payment	□ Charity Care	□ Both
Notice to Discounted Payment Only Applicants		
Patients who apply only for Discounted Payment program eligibility may receive less financial assistance than what may be available to them under the Charity Care program.		
Patient Information		
Account Number(s):		
Name:	Telephone Number:	
Address:		
City:	State:	Zip:
Guarantor/Applicant Information		
Relationship to patient: □ Self □ Parent/Guardian		
Name:		Date of birth:
SSN:	Telephone Number:	
Address:		
City:	State:	Zip:
Definition of Family Size:		

- For patients 18 years of age and older, Patient's Family is defined as their spouse, domestic partner, and dependent children under 21 years of age, or any age if disabled, whether living at home or not.
- For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, Patient's Family is defined as their parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled.

Number of Persons in Your Family:

Required Documents for Discounted Payments & Charity Care Applications

For All Members of the Patient's Family

- A recent tax return, meaning a tax return which documents a patient's income for the year in which a patient was first billed or 12 months prior to when the patient was first billed.

• Recent paystubs, meaning pay stubs that are within a 6-month period before a patient is first billed by the Hospital, or in the case of preservices, when the Application is submitted, or a letter from the employer.
Optional Documentation of Proof of Income (For All Members of the Patient's Family)
• Unemployment benefits (check stubs).
• Social Security benefits (copy of check or letter from Social Security).
• Department of Social Services grants and/or amount of food stamps.
• Information regarding employment status and future earning capacity.
• Other information regarding financial resources as the patient may choose to provide.
Optional Documentation of Proof of Expenses (For All Members of the Patient's Family)
• Copy of mortgage payment or rental agreement.
• Copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable, and cell phones).
• Out-of-pocket medical bills/expenses for the last 12 months, including medical bill balances, co-insurance, co-payment or deductible amounts.
• Other information regarding financial obligations as the patient may choose to provide.

Additional Information	
Are you eligible for coverage with a Commercial Health Insurance? If yes, please provide the name of your Health Insurance, Phone Number and Identification Number:	□ Yes □ No
Are you eligible for coverage with Medicare? If yes, please provide the scope of your coverage (A, B or both) and your identification number:	□ Yes □ No
Are you eligible for coverage with Medi-Cal or any other state medical assistance program? If yes, please provide the County of coverage and your identification number:	□ Yes □ No
Is your treatment related to an injury covered by Workers Compensation? If yes, please provide the name of the Workers Compensation Carrier and your claim number:	□ Yes □ No
Is your treatment covered by Third Party Liability? (such as a car accident of slip and fall)? If yes, please provide the name of the auto carrier and your claim number:	□ Yes □ No
Is your treatment a result of you being a victim of a crime incident? If yes, please provide the name of your Case Worker and your case number:	□ Yes □ No

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Patient Attestation
The information provided in this application is subject to verification by Hospital and has been provided to determine my ability to pay my debt. I attest that the financial information I have provided is complete and accurate and I agree that your facility may verify this information. I understand that any false information provided by me will result in denial of any financial assistance by the hospital. I agree to notify Hospital of any changes in my financial circumstances and to provide, upon request, insurance eligibility status. Patient's Signature _____ Date _____ (If the patient is under 18 years of age, the signature of a parent or guardian is required) Parent/Guarantor's Signature _____ Date _____ Patient Representative's Signature _____ Relationship _____ (If the patient is unable to sign because of illness or disability) Hospital Representative Completing Application _____

For Office Use Only:

Approval/Authorization of Discounted Payment or Charity Write-Off

The below signatures are an indication of your review of the application and supporting documentation and that you find the information to meet policy requirements.

Amount: $ _____ CEO: _____

BOM: _____ CFO: _____