**PURPOSE**

As declared in our mission statement, Community Hospital of the Monterey Peninsula ("Community Hospital") is committed to caring for all who come through our doors, regardless of ability to pay, to the fullest extent allowed by law and available resources. This policy is intended to provide the framework of our Sponsored Care Program and Discount Payment Program.

**POLICY**

In addition to the information set forth in this policy, patients should be aware that there are organizations that will help the patient understand the billing and payment process, as well as information regarding Covered California and Medi-Cal presumptive eligibility. Patients may visit the Health Consumer Alliance website for more information, https://healthconsumer.org. Patients may also access Community Hospital's list of shoppable services at, https://www.montagehealth.org/patient-family-resources/financial/cost-care-estimates/.

A. Uninsured patients and patients with high medical costs whose income is at or below 400 percent of the federal poverty level are eligible to apply for financial assistance for medically necessary hospital and hospital-based physician services provided by Community Hospital of the Monterey Peninsula. Qualifying applicants will be granted the highest award for which they are eligible.

    1. Sponsored Care – This program may give a patient a discount of up to 100 percent on the services she or he received. To qualify, the patient's gross family income must not be higher than 400 percent of the federal poverty level. Patients must provide information and documentation about their family members' income and the value of assets and about any health benefits coverage they have.

    2. Discount Payment Program – This program may give a patient a discount to reduce the amount she or he owes. To qualify, the patient's gross family income must not be higher than 400 percent of the federal poverty level. Patients must provide information and documentation about their family members' income and the value of assets and about any health benefits coverage they have.

B. Applications from patients whose income is above 400 percent of the federal poverty level will also be thoroughly reviewed, and awards will be granted on a case-by-case basis.

C. Emergency department physicians who provide emergency medical services at Community Hospital are required to provide discounts to uninsured patients and patients with high medical costs whose income is at or below 400 percent of the federal poverty level.

D. Current and prospective patients may apply for the Sponsored Care Program or the Discount Payment Program. Information about these programs is available at all patient intake and treatment locations within Community Hospital facilities and is provided to each patient presenting for services. An application for the Sponsored Care and Discount Payment programs will be provided to all patients who request one. Additionally, enrollment counselors are available to provide information and applications for Medi- Cal, Medicare, California Health Benefit Exchange, and other available government programs. A pre-screening interview may be done with patients to ensure that they meet the basic eligibility criteria.

E. The criteria Community Hospital will follow in verifying a patient's eligibility for financial assistance programs are described in this policy. Upon approval, financial assistance is provided through one of two programs: (1) the Sponsored Care Program; or (2) the Discount Payment Program. These programs may cover all or part of the cost of services provided, depending on the patient's eligibility, income, and resultant ability to pay for services. The Sponsored Care and Discount Payment programs are intended for patients who's personal or family financial ability to meet hospital expenses is absent or demonstrably restricted. The minimum requirement for both programs is stated below and is based upon the patient's combined family income as a percentage of the applicable federal poverty level (FPL) as published annually in the Federal Register (http://aspe.hhs.gov/poverty). Given Community Hospital service area demographics, available resources, and mission to meet the healthcare needs of its community, financial assistance is available for patients with income levels up to 400 percent of the FPL for the patient's family size. Community Hospital's Sponsored Care and Discount Payment programs are intended to fully comply with the Hospital Fair Pricing Policies Act and Section 501(r) of the Internal Revenue Code. This policy is intended to be stated as clearly and simply as possible for the benefit of our patients.

   Financial Assistance may be applied to uninsured patients, as well as the patient liability for patients with insurance, including charges determined uninsured for the hospital stay, coinsurance, copayment, deductible amounts, and other liabilities for medically necessary hospital services. Policy AD-1029 details Montage Health's process to determine eligibility for this program.

   Non-covered and denied services provided to Medicaid eligible beneficiaries are considered a form of charity care. Medicaid beneficiaries are not responsible for any forms of patient financial liability and all charges related to services not covered, including all denials, are charity care. Examples may include, but are not limited to:

   - Services provided to Medicaid beneficiaries with restricted Medicaid (i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care)
   - Medicaid-pending accounts
   - Medicaid or other indigent care program denials
   - Charges related to days exceeding a length-of-stay limit
   - Medicaid claims (including out of state Medicaid claims) with "no payment""
   - Any service provided to a Medicaid eligible patient with no coverage and no payment

   Any unreimbursed charges from non-covered or denied services from any payor, such as charges for days beyond a length-of-stay limit, exhausted benefits, balance from restricted coverage, Medicaid-pending accounts, and payor denials are considered a form of patient financial assistance at Community Hospital. Charges related to these denials/non-covered amounts written off during the fiscal year are reported as uncompensated care.

F. Discovery of Patient Financial Assistance Eligibility during Collections. While Community Hospital strives to determine patient financial assistance as close to the time of service as possible, in some cases further investigation is required to determine eligibility. Some patients eligible for financial assistance may not have been identified prior to initiating external collection action. The collection agencies shall be made aware of this possibility and are requested to refer-back patient accounts that may be eligible for financial assistance. When it is discovered that an account is eligible for financial assistance, Community Hospital will reverse the account out of bad debt and document the respective discount in charges as charity care.

G. Negotiations with insurance carriers involving inferred contractual relationships for insured patients not under contract with Community Hospital will be conducted by executive management. Although Community Hospital may agree to the terms of the negotiations with insurance companies, an inferred contractual relationship is not representative of a patient "under contract" with the hospital. Community Hospital considers any reimbursement less than 20% of cost to be charitable event. Any care provided to a presumptive or actual case of COVID-19 is provided at an amount no greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider. All unreimbursed amounts are a form of patient financial assistance and determined as the difference between gross hospital charges and hospital reimbursement.

**Applying for Assistance**

A. Requests for financial assistance may be made verbally or in writing at any point before, during, or after the provision of care.

B. Applications for Sponsored Care or Discount Payment program must be submitted to the Care Coordination Services department prior to service or to the Patient Business Services or Patient Access department during and/or after receiving services by using the *Application for Sponsored Care or Discount Payment Program*. The application must be received within 240 days of the original bill date. Incomplete applications will be kept on file until all information is received. In addition to a completed application, a letter explaining the patient's circumstances and/or a letter from the person(s) providing living assistance to the patient may be required to determine eligibility.

- See Eligibility Criteria below.

A patient (or a patient's legal representative) who requests Sponsored Care or Discount Payment, must make every reasonable effort to provide documentation of income and health benefits coverage. Uninsured patients, who are eligible for a government-sponsored health benefit plan, or health benefit coverage through the California Health Benefit Exchange with a government subsidy, will be encouraged to apply for those programs and comply with the application requirements for those programs. This also applies to patients who are at or below 138 percent of the federal poverty level, who are eligible for modified adjusted gross income Medi-Cal. Hospital enrollment counselors will be available to assist patients with the application process for government-sponsored health benefit plans, health benefit coverage through the California Health Benefit Exchange, Medi-Cal, Medicare, and other available programs. When patients do not cooperate with the enrollment counselors, Community Hospital will make reasonable

effort, through letters and telephone calls, to encourage patients to cooperate prior to its review and decision regarding Sponsored Care and/or Discount Payment eligibility. Applications may be denied and the associated account(s) referred to a collection agency if documentation sufficient to determine eligibility is not provided.

C. If a patient applies or has a pending application for another health coverage program at the same time they apply for the hospital Sponsored Care or Discount Payment Program, the pending status of either application shall not prevent or delay the review of or action on the other.

D. This policy applies only to emergency and medically necessary services provided by Community Hospital. Services provided at a hospital facility by private healthcare providers, such as personal physicians and ambulance conveyance, are not covered by the Sponsored Care and Discount Payment programs. Community Hospital maintains a list of providers delivering emergency or other medically necessary care covered by the Sponsored Care and Discount Payment programs. The list is available on the hospital's website at: www.chomp.org. These programs are available only for emergency and medically necessary services provided by Community Hospital that are not paid for by any other government programs and/or funding sources, including third-party insurance coverage for which an individual applicant is eligible. See the list of non-covered services below.

**Non-Covered Services**

A. All healthcare services not billed by Community Hospital, such as non-hospital based physician services and ambulance transportation;

B. Non-medically necessary bariatric surgery;

C. Cosmetic services;

D. Services which, in the opinion of competent hospital staff, are provided only as a stop- gap when a patient is staying at the hospital, or at Westland House, for the convenience of the family and/or physician;

E. Non-medically indicated care;

F. Durable medical equipment;

G. Oxygen and oxygen supplies, except when pre-approved;

H. Any service or product considered to be experimental;

I. Services or products unapproved for patient use by the FDA; and

J. Services or products that would effectively place the hospital in the position of having to provide such services or products for extended periods of time, including when the patient is not a patient of Community Hospital.

**Discount Payment Program**

Community Hospital is committed to providing qualifying uninsured patients and patients with high medical costs, as defined below, with a discount that exceeds that provided to participants in the Medicare program. The Medicare program, the highest paying government-sponsored health benefit program accepted by Community Hospital, currently reimburses the hospital an average of 18 percent of total charges, representing 82 percent discount. As an expanded benefit to patients who qualify for the Discount Payment Program, the patient's obligation will be limited to 18 percent of total charges, representing 82 percent discount. No

individual who qualifies for the Discount Payment Program will be charged more than the amount generally billed ("AGB") by Community Hospital to individuals who have insurance covering such emergency and/or medically necessary care. Community Hospital calculates the AGB using the prospective Medicare method described in 26 C.F.R. § 1.501(r)-5(b)(4).

A. Uninsured patients who qualify for the Discount Payment Program will also be eligible for a zero-interest extended payment plan on the remaining balance. Insured patients who are eligible for the Discount Payment Program due to high medical costs as defined below will receive a 100-percent discount on all charges in excess of the amount paid by their insurance, provided their insurance has paid at least 18 percent of total charges.

B. The total gross charge for services and the discount to be applied will be shown on the award letter. These discounts apply to co-payments, deductibles, co-insurance amounts, and non-covered medical amounts.

C. Demonstrating Eligibility

1. Uninsured patients and patients with high medical costs applying for the Discount Payment Program are required to provide prior year's tax return, and if no tax was filed, documentation of family income in the form of three months of recent pay stubs is accepted. If the patient is from out of the country, the hospital may request an affidavit to prove income eligibility. For purposes of determining eligibility, neither retirement or deferred compensation plans qualified under the Internal Revenue Service code nor nonqualified deferred compensation plans shall be included. Qualifying income must not exceed 400 percent of the applicable federal poverty level. Patients claiming to have high medical costs must demonstrate proof of costs incurred at the hospital or paid medical expenses as outlined in the Definition section of this policy.

D. Payment Plan

1. Patients who qualify for the Discount Payment Program will also be eligible for an interest-free payment plan not to exceed 72 months in duration. In situations where an agreement cannot be reached, a minimum monthly payment amount should not exceed 10 percent of the patient's family's monthly income (after essential living expenses). Any payment plan that remains unpaid for 90 consecutive days will be declared delinquent, and may be advanced for collection activity after attempts have been made to renegotiate the terms of the defaulted payment plan. See *Procedure for Financial Assistance Program, Sponsored Care and Discount Payment Program AD- 1029.*

**Sponsored Care (free care or charity care)**

A. Community Hospital is committed to providing qualifying uninsured patients and patients with high medical costs, as defined below, with a 100 percent discount on the amount determined to be due from the patient. This discount applies to co-payments, deductibles, co-insurance amounts, and non-covered amounts.

B. Requests for financial assistance may be made verbally or in writing at any point before, during or after the provision of care.

C. Demonstrating Eligibility

1. Uninsured patients and patients with high medical costs applying for Sponsored Care are required to provide documentation of family income in the form of prior year's tax return. If the prior year's tax return was not filed, three months of recent pay stub will be accepted. Patients claiming to have high medical costs must demonstrate proof of costs incurred at the hospital or paid medical expenses as outlined in the Definition section of this policy.

D. Presumptive Charity Care

Financial assistance may be granted in the absence of a completed application in situations where the patient does not apply but other available information substantiates a financial hardship. Examples of these exceptions where documentation requirements are waived include, but are not limited to:

- An independent credit-based financial assessment tool indicates indigence
- An automatic financial assistance determination of 100% assistance is applied in the following situations provided other eligibility criteria are met:
  - Patient has an active Medicaid plan
  - Patient is eligible for Medicaid or patients with current active Medicaid coverage will have assistance applied for past dates of service
  - Patient is deceased
- Determination of patient financial assistance eligibility.

Presumptive eligibility tools may not be used for indigent Medicare patients.

**Dispute process**

Any patient who wishes to dispute the determination made on their application for assistance may request a review of the original application by the director of Patient Business Services provided the request is submitted in writing within 30 days of the latest denial date. The director's eligibility determination will be final.

**Special circumstances**

Uninsured patients and patients with high medical costs with income that exceeds 400 percent but is less than 500 percent of the applicable federal poverty level will be awarded a 25 percent discount on total charges and will also be eligible for a zero-interest extended payment plan for the remaining balance.

**Payments in excess of amount due after discount**

In the event the Community Hospital collects payments from a patient who subsequently qualifies for the Sponsored Care or Discount Payment Policy, Community Hospital will refund any excess previously paid by the patient, together with interest thereon at the current rate (refer to refund procedure) per annum from the date Community Hospital received the overpayment, or the date the patient qualifies for the Sponsored Care or Discount Payment Policy, whichever date is later. This does not apply to overpayment less than $5. Community Hospital will refund the patient within 30 days.

**Policy maintenance and reporting**

This policy document is to be reviewed annually for consistency with all applicable laws and available resources. Additionally, this information must be submitted to California Department of Health Care Access and Information every other year on January 1, or whenever a significant change is made. In order to make the Sponsored Care and Discount Payment policies available to the community, the hospital will publish the policy and application on the hospital website and include information about how to apply in its initial billing statements.

**Practice**

See procedure document *Sponsored Care and Discount Payment Program AD-1029.*

**Definitions**

The following terms have the following meanings:

A. *Federal poverty level* means the poverty guidelines specific to income and family size, which are updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

B. *A patient with high medical costs* means a person whose family income does not exceed 400 percent of the applicable federal poverty level who has:

1. annual out-of-pocket costs 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;

2. annual out-of-pocket medical expenses that exceed 10 percent of the patient's 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; or a lower level determined by the hospital in accordance with the hospital's charity care policy.

C. *Patient's family* means the following:

1. For persons 18 years of age and older, family includes spouse, domestic partner as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.

2. For persons under 18 years of age, family includes parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

D. *Hospital-based physicians* means the doctors who provide services at Community Hospital and are billed under Community Hospital's Provider Identification Number (PIN). These include Emergency department physicians, radiologists, pathologists, cardiologists, radiation oncologists, and psychiatrists.

### Access to Healthcare During a Public Health Emergency

Executive leadership must proclaim an Access to Healthcare Crisis; an Access to Healthcare Crisis may be related to an emergent situation whereby state / federal regulations are modified to meet the immediate healthcare needs of Community Hospital's community during the Access to Healthcare Crisis. During an Access to Healthcare Crisis, Community Hospital may "flex" its patient financial assistance policy to meet the needs of the community in crisis. These changes will be included in the patient financial assistance policy as included as an addendum if an Access to Healthcare Crisis is proclaimed. Patient discounts related to an Access to Healthcare Crisis may be provided at the time of the crisis, regardless of the date of this policy (as hospital leadership may not be able to react quickly enough to update policy language in order to meet more pressing needs during the Access to Healthcare Crisis).

| CONTENTS | DESCRIPTION |
|---|---|
| **Submitted by:** | Director, Revenue Cycle |
| **Next review date:** | January 2025 |
| **Effective date:** | January 2022 |
| **Applicable to:** | Patient Business Services Staff, Patient Access Staff, Social Services Staff, Radiology Staff, Rehabilitation and Wound Staff, Diabetes and Nutrition Staff, Cardiology Staff, 'Ohana Staff. |
| **Approved by:** | Patient Business Services, Patient Access, Social Services, Radiology, Rehabilitation and Wound, Diabetes and Nutrition, Cardiology, 'Ohana President's Administrative Committee (PAC), The Board. |
| **Reviewed by:** | Patient Access, Patient Business Services, Social Services, Radiology, Rehabilitation and Wound, Diabetes and Nutrition, Cardiology, 'Ohana. PAC, The Board |
| **Replaces:** | |
| **References:** | Patient Business Services Procedure: Sponsored Care and Discount Payment Program, Federal poverty level defined in the Federal Register (http://aspe.hhs.gov/poverty). |
| **Key Words:** | Low income, federal poverty level, family income, charity care, financial assistance eligibility criteria and application, enrollment counselor. |
| **Distribution:** | CHOMP Intranet Policies and Procedures; Patient Business Services Staff. Patient Access Staff, Social Services Staff, Radiology Staff, Rehabilitation and Wound Staff, Diabetes and Nutrition Staff, Cardiology Staff, 'Ohana Staff. |
| **Additional information:** | |
| **Related policies or programs:** | *Procedure for Financial Assistance Program, Sponsored Care and Discount Payment Program AD-1029 and AD-1031 General Administrative Policy – Collection Policy* |

Community Hospital
of the Monterey Peninsula
Montage Health

# APPLICATION FOR SPONSORED CARE OR DISCOUNT PAYMENT PROGRAM

This is an application for the Sponsored Care and Discount Payment programs.

To be considered for financial assistance, a completed application must be submitted to our office no later than 240 days from the original bill date. Due to the length of time allowed to submit an application, late submissions will not be considered.

Please be sure to attach required documentation as indicated on the application.

This program is the payer of last resort and should only be accessed after all other means of payment have been exhausted. This means that you need to apply for any and all government programs for which you may be eligible, such as Medicare, Medi-Cal and the California Health Benefit Exchange. To be eligible your claim cannot be covered by any Third Party Liability (TPL) or Workers Compensation insurance. Enrollment Counselors are available at Community Hospital to help you through the application processfor most government programs.

If you apply and are deemed eligible by Community Hospital for Sponsored Care or the Discount Payment Program, you will be notified of the discount amount for which you have been approved. This program does not cover fees and charges from other providers (including physicians) for which Community Hospital does not bill, nor does not cover transportation costs (i.e. ambulance).

If you have questions regarding the completion of your application please call us at any of these numbers:

For information **prior** to care or services contact the clinical department where you are seeking services.

For information **during** care contact Patient Access (831) 625-4910

For information **after** care contact Patient Business Services (831) 625-4922

Help Paying Your Bill - There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

Hospital Bill Complaint Program - The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to - HospitalBillComplaint.hcai.ca.gov for more information and to file a complaint.

Community Hospital
of the Monterey Peninsula
Montage Health

# APPLICATION TO DETERMINE SPONSORED CARE OR DISCOUNT PAYMENT PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if independent and age18 or older or an emancipated minor) in order to determine if the applicant is eligible for Community Hospital 's Sponsored Care or Discount Payment Program. The term "applicant" means the patient for whom Community Hospital provided or will provide medical services. Please type or print clearly.

## A. APPLICANT INFORMATION

1. Name of applicant (Last, first, middle): _____
2. Any other name the applicant is known by: _____
3. Date of birth (Month, day, year): _____
4. Social Security number: _____
5. Residence address:

_____

Number and street (do not use P.O. Box) City State Zip

6. Mailing address (if different from residence):

_____

Number and street (do not use P.O. Box) City State Zip

7. Daytime phone number:_____ 8. Evening phone number: _____
9. What is your preferred language? _____
10. Type of service provided or requested: _____
11. The Sponsored Care and Discount Payment programs require submission of the following documentation:
    - Signed completed application form
    - Proof of income:
        - Copy of your federal tax return transcript of recent tax year. Must be obtained through the IRS website.
            - Log into WWW.IRS.GOV
            - Click on Get Your Tax Record
            - Scroll down to" Request Online"
            - Click on Get Transcript Online and follow instructions.

          Detailed instructions can be provided upon request.
        - Pay stubs from the past 3 months, for all members of the family
        - Copy of most recent W2 form (Sponsored Care Program only) for the following family members: spouse, domestic partner, dependent children, and parent if applicant is a minor.

    You may be asked to provide additional documentation, including but not limited to the following:

    - Proof of out-of-pocket medical, dental, pharmacy, and insurance premium expenses, such as receipts
    - Additional supporting documentation of lack of income

**B. PARENT/LEGAL GUARDIAN INFORMATION (Applicants age 18 or older or emancipated minors skip items 13 through 18)**

13. Name(s) of parent or legal guardian:_____Relationship: _____
14. Residence address:

_____

Number and street (do not use P.O. Box) City State Zip

15. Mailing address (if different from residence):

_____

Number and street (do not use P.O. Box) City State Zip

16. Daytime phone number:_____17. Evening phone number: _____

18. Message phone number: _____

**C. HEALTH INSURANCE INFORMATION**

19. Does the applicant have Medi-Cal? If yes, what is the applicant's Medi-Cal ID number?
20. Does the Applicant have other health insurance including but not limited to:
    - Third Party insurance coverage
    - Eligibility or active coverage with the California Health Benefit Exchange
21. Total paid out of pocket medical expenses for the past 12 months $_____attach proof of payment

| | |
|---|---|
| _____ Initial here | I am applying for the hospital's Sponsored Care or Discount Payment Program as indicated above. I understand that failure to provide requested information by the due date will result in denial of my application. |
| _____ Initial here | I certify that I have read and understand the information on this application. |
| _____ Initial here | I certify that the information I have given on this form is true and correct. |
| _____ Initial here | I give my permission for Community Hospital of the Monterey Peninsula to contact any healthcare provider regarding my medical care and treatment. |
| _____ Initial here | I understand and agree that a credit report will be run on all Sponsored Care requests. Other verifications such as employment and property ownership searches may be conducted at the hospital's discretion. |

Additional comments: _____

_____

_____

_____

_____ _____

Applicant's signature Today's date

Community Hospital
of the Monterey Peninsula
Montage Health

# SOLICITUD DE PROGRAMA DE CUIDADOS PATROCINADOS O PROGRAMA DE PAGO CON DESCUENTO

La presente es una solicitud de Programa de Cuidados Patrocinados y Programa de Pago con Descuento.

Para que se lo considere para recibir asistencia financiera, debe presentarse una solicitud completada a nuestra oficina no después de 240 días desde la fecha de la factura original. Debido al periodo prolongado que se otorga para presentar una solicitud, las presentaciones tardías no serán consideradas.

Asegúrese de adjuntar la documentación requerida según se indica en la solicitud.

Este programa es el pagador en última instancia, al que solo debería accederse luego de agotarse todoslos otros medios de pago. Esto significa que usted debe solicitar cualquier y todo programa gubernamental para el que pueda resultar elegible, tales como Medicare, Medi Cal y el California Health Benefit Exchange. Hay disponible Asesores de Inscripción en el Community Hospital para ayudarle con el proceso de soicitud de la mayoría de los programas gubernamentales.

Si usted presenta una solicitud y es considerado elegible por Community Hospital para el Programa de Cuidados Patrocinados o el Programa de Pago con Descuento, será notificado sobre el monto del descuento para el que haya sido aprobado. Este programa no cubre gastos y cargos de otros prestadores(incluidos medicos). Community Hospital no cubre costos de transporte (por ej. ambulancia).

Si tiene preguntas acerca de cómo llenar su solicitud, llámenos a cualquiera de estos números:

Para obtener información **antes** de recibir atención o servicios comuníquese con el departamento clínico donde está buscando servicios.

Para información **durante** los cuidados medicos comuniquese acceso del paciente (831) 625-4910

Para información después de los cuidados medicos comuniquese: Servicios Administrativos del Paciente (831) 625-4922

Ayuda para pagar su factura - Existen organizaciones gratuitas de defensa del consumidor que le ayudarán a comprender el proceso de facturación y pago. Puede llamar a Health Consumer Alliance al 888-804-3536 o visitar healthconsumer.org para obtener más información.

Programa de quejas de facturas hospitalarias - El Programa de quejas de facturas hospitalarias (*Hospital Bill Complaint Program*) es un programa estatal que revisa las decisiones del hospital sobre si usted califica para recibir ayuda para pagar su factura hospitalaria. Si cree que se le negó asistencia financiera por error, puede presentar una queja ante el Programa de quejas de facturas hospitalarias. Vaya a HospitalBillComplaint.hcai.ca.gov para obtener más información y presentar una queja.

# SOLICITUD PARA DETERMINAR LA ELEGIBILIDAD PARA ELPROGRAMA DE CUIDADOS PATROCINADOS O EL PROGRAMA DE PAGO CON DESCUENTO

Esta solicitud debe ser completada por el padre/madre, tutor legal o solicitante (de ser independiente y tener 18 años deedad o más, o un menor emancipado) para determinar si el solicitante es elegible para el Programa de Cuidados Patrocinados ode Pago con Descuento de Community Hospital. El término "solicitante" significa el paciente para el que Community Hospital prestó o prestará servicios médicos. Por favor, escriba claramente con letra de molde o imprenta.

## A. INFORMACIÓN DEL SOLICITANTE

1. Nombre del solicitante (apellido, primer nombre, segundo nombre): _____
2. Cualquier otro nombre por el que se conozca al solicitante: _____
3. Fecha de nacimiento (mes, día, año): _____
4. Nro. de seguro social: _____
5. Domicilio:

| Número y calle (no use Apartados Postales) | Ciudad | Estado | Código postal |
|---|---|---|---|

6. Dirección postal (si es diferente de la residencia):

| Número y calle (no use Apartados Postales) | Ciudad | Estado | Código postal |
|---|---|---|---|

7. Teléfono de contacto durante el día:_____8. Teléfono de contacto durante la noche: _____
9. ¿Qué idioma habla en casa?_____
10. Tipo de servicio provisto o solicitado: _____
11. Los Programas de Cuidados Patrocinados y de Pago con Descuento requieren la presentación de lasiguiente documentación:
    - For favor de firmar la solicitud.
      Prueba de ingresos:
      - Copia de la transcripcion de la declaración de impuestos federales. Es requisito obtenerlo del sitio de internet del IRS
        - Iniciar Sesión WWW. IRS.GOV
        - Selecione en "ordene su Transcripción"
        - desplácese hacia abajo hasta "solicite en línea"
        - selecione en "obtenga una transcripción en línea (en Ingles)" y siga las instrucciones

        Se pueden proporcionar instrucciones detalladas a pedido.
      - Recibos de sueldo de los últimos 3 meses, para todos los miembros de la familia
      - Copia del formulario W2 más reciente (Programa de Cuidados Patrocinados únicamente) de lossiguientes miembros de la familia: cónyuge, pareja doméstica, hijos dependientes, y padre/madre si el solicitante es menor de edad.

    Podrá pedírsele que suministre documentación adicional, como ser, a modo de ejemplo:
    - Prueba de gastos de bolsillo médicos, dentales, de farmacia y primas de seguro, como por ejemplo recibos
    - Documentación de soporte adicional de falta de ingresos

**B. INFORMACIÓN PARA LOS PADRES/TUTORES LEGALES (Solicitantes de 18 años de edad o mayores, o menores emancipados saltear los puntos 13 al 18)**

13. Nombre(s) del padre/madre o tutor legal:_____Parentesco: _____
14. Domicilio:

_____

Número y calle (no use Apartados Postales) Ciudad Estado Código postal

15. Dirección postal (si es diferente de la residencia):

_____

Número y calle (no use Apartados Postales) Ciudad Estado Código postal

16. Teléfono de contacto durante el día:_____17. Teléfono de contacto durante la noche: _____

18. Teléfono para mensajes: _____

**C. INFORMACIÓN DE SEGURO DE SALUD**

19. ¿El solicitante tiene Medi-Cal? En caso afirmativo, ¿cuál es el número de ID de Medi-Cal del solicitante?
20. ¿El solicitante tiene otro seguro de salud incluido, a modo de ejemplo:
    - Cobertura del seguro de terceros
    - Elegibilidad o cobertura activa con California Health Benefit Exchange
21. Gastos médicos totales de bolsillo pagados durante los últimos 12 meses $_____adjuntar prueba de pago

| | |
|---|---|
| _____ Inicializar aquí | Estoy solicitando el Programa de Cuidados Patrocinados o Pago con Descuento del hospital según se indica arriba. Entiendo que no brindar la información solicitada antes de la fecha límite resultará en la denegación de mi solicitud. |
| _____ Inicializar aquí | Certifico que he leído y entiendo la información contenida en esta solicitud. |
| _____ Inicializar aquí | Certifico que la información que he dado en este formulario es verdadera y correcta. |
| _____ Inicializar aquí | Doy mi permiso para que Community Hospital of the Monterey Peninsula contacte a cualquier prestador de cuidados de salud respecto de mi tratamiento y mis cuidados médicos. |
| _____ Inicializar aquí | Entiendo y acepto que se realizará un informe de crédito respecto de todas las solicitudes para Cuidados Patrocinados. Podrán realizarse, a criterio del hospital, otras verificaciones como ser investigaciones de empleo y titularidad de bienes. |

Comentarios adicionales:

_____

_____

_____

_____ _____

Firma del solicitante Fecha de hoy