AHMC Healthcare Financial Assistance

Plain Language Summary and Application

Revision Date: April 20, 2026

Plain Language Summary

AHMC Healthcare wants to help you pay your hospital bill. California law requires hospitals to offer financial assistance to people who cannot afford to pay. You may qualify for free care or reduced-price care based on your household size and income, even if you have health insurance.

Who Can Get Help?

- If your family income is at or below 200 percent of the Federal Poverty Level, you may qualify for free care (Charity Care).
- If your family income is between 201 percent and 400 percent of the Federal Poverty Level, you may qualify for reduced-price care (Discount Payment).
- If your out-of-pocket medical costs are very high compared to your income, you may qualify even if your income is higher (High Medical Costs).
- Anyone can apply, regardless of immigration status.

What Is Covered

Financial assistance covers medically necessary care provided by our hospitals. Some services may not be covered, such as care from outside doctors or providers who bill separately. Ask our Financial Counselor if you have questions about a specific bill.

Your Rights

- You can apply at any time. There is no deadline. You can apply even if you have already paid your bill or your bill has been sent to a collection agency.
- We will not consider your savings, bank accounts, stocks, bonds, or retirement accounts when deciding whether you qualify.
- We will not report your medical bill to a credit bureau. This is true whether you pay, pay late, or do not pay.
- We will not place a lien on your home or other real property.
- We will not require you to apply for Medi-Cal before we decide if you can get a discount, though we may ask you to participate in Medi-Cal screening.
- You can get help filling out the application. Just ask.
- You can get this application, this summary, and the full policy in your language, free of charge.

How to Apply

Fill out the application below and give it to us. You can submit it in person at the hospital Financial Counselor office, by mail, by email, or by fax. See the back cover for contact information.

What You Need to Provide

- Information about your family size
- Proof of your family income (recent pay stubs or last year tax return)

- If you have no income, a short note explaining how you pay for your basic needs

What Happens Next

After we receive your complete application, we will tell you in writing within 14 to 30 days whether you qualify. While your application is being reviewed, we will not send your bill to collections. If you qualify and have already paid part of your bill, we will refund you.

If You Have Questions or Need Help

Our Financial Counselors are here to help. You can call them, email them, or visit in person. Contact information for each AHMC hospital is on the back cover of this application. You can also call the Health Consumer Alliance for free help at 1-888-804-3536, or visit https://healthconsumer.org.

If You Think You Were Treated Unfairly

If you believe you were wrongly denied financial assistance, you can file a complaint with the State of California Hospital Bill Complaint Program at https://HospitalBillComplaintProgram.hcai.ca.gov. Filing a complaint is free. We will not retaliate against you for filing a complaint.

Application Instructions

This is an application for financial assistance (also known as charity care) at any AHMC Healthcare, Inc. affiliated hospital.

Federal and state law require all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance.

What Does Financial Assistance Cover?

Financial assistance covers medically necessary care provided by AHMC hospitals or clinics. Financial assistance may not cover all health care costs, including services provided by other organizations (such as outside physicians or labs).

Anyone Can Apply

Anyone can apply for financial assistance regardless of immigration status. Applying is free. You do not need to create an account or provide personal information to get information about financial assistance.

Your Rights

- **No deadline to apply.** You may apply at any time, including after you have received services, after you have been billed, after you have paid some or all of the bill, or after your account has been sent to collections.
- **No assets considered.** We will not consider your monetary assets, such as checking, savings, stocks, bonds, or retirement accounts, when deciding whether you qualify.
- **No credit reporting.** We will not report your medical bill to a consumer credit reporting agency at any time.
- **No real property liens.** We will not place a lien on your home or any other real property.
- **No requirement to apply for coverage first.** We will not require you to apply for Medicare, Medi-Cal, or other coverage before we screen you for Discount Payment. We may require you to participate in Medi-Cal screening. For Charity Care, we may require you to apply for other coverage.

If You Have Questions or Need Help

Our financial assistance policies, information about the programs, and application materials are available on our website or by phone. You may obtain help for any reason, including disability and language assistance. Translated written documents are available on request. You do not need to create an account or provide personal information to obtain information about financial assistance.

How to Complete This Application

To process your application, you must:

- **Provide information about your family.** Fill in the number of family members in your household. Family includes people related by birth, marriage, or adoption who live together. If the patient is 18 or older, family includes spouse, domestic partner, and dependent children under 21 (or any age if disabled). If the patient is under 18 or is a dependent child 18 to 20 years old, family includes parents, caretaker relatives, and parent or caretaker relatives' other dependent children under 21 (or any age if disabled).
- **Provide information about your family gross monthly income** (income before taxes and deductions). Acceptable documentation: recent pay stubs (within 6 months) or income tax returns. We may accept, but do not require, other forms such as W-2 forms, Social Security award letters, or employer statements.

- **Attach additional information if needed.**
- **Sign and date the application.**

Social Security Number

You do not have to provide a Social Security number to apply for financial assistance. If you provide your Social Security number, it may be used to identify you or to verify information you provided. If you do not have a Social Security number, please mark not applicable or NA.

How to Submit

You may submit your application in any of these ways:

- In person at the Financial Counselor office at any AHMC hospital
- By mail to the centralized address below
- By email or fax (see contact information on back cover)

Centralized Mailing Address: AHMC Healthcare, Inc. - Financial Assistance, 500 E Main Street, Alhambra, CA 91801, Attention: Director of CBO

What Happens After You Apply?

- We will notify you of the final determination of eligibility, and of your appeal rights if applicable, within 14 to 30 days of receiving a complete financial assistance application including income documentation.
- Once a complete application is received, AHMC will suspend any collection activity on the account until a determination is made. You will continue to receive informational billing statements, but your account will not be sent to collections, sued, or otherwise subject to extraordinary collection actions during this period.
- If we determine you were eligible for financial assistance at the time of service and you have already paid some or all of your bill, we will refund you within 30 days with interest.

Your Consent

By submitting this application, you give consent for AHMC to make necessary inquiries to verify the income and family-size information you provided. Monetary assets, credit reports, and credit history will not be used to determine your eligibility.

AHMC Healthcare Financial Assistance Application - Confidential

Please fill out all information completely. If a question does not apply, write NA. Attach additional pages if needed.

Section A. Screening Information	
Do you need an interpreter? If yes, preferred language: _____	☐ Yes ☐ No
Has the patient applied for Medi-Cal?	☐ Yes ☐ No
Is the patient blind?	☐ Yes ☐ No
Is the patient disabled?	☐ Yes ☐ No
Does the patient receive state public services such as TANF, CalFresh (SNAP), or WIC?	☐ Yes ☐ No
Is the patient currently homeless?	☐ Yes ☐ No
Is the patient medical care need related to a car accident or work injury?	☐ Yes ☐ No

Note: You are not required to apply for Medi-Cal before applying for Discount Payment. We may ask you to participate in Medi-Cal screening. For Charity Care, we may require you to apply for other coverage.

Section B. Patient and Applicant Information		
Patient First Name	**Patient Middle Name**	**Patient Last Name**
Sex/Gender ☐ Male ☐ Female ☐ Other: _____	**Birth Date**	**Patient Social Security Number (optional)**

Person Responsible for Paying Bill	**Relationship to Patient**
Birth Date	**Social Security Number (optional)**

Mailing Address (Street, City, State, ZIP)

Main Contact Phone (1)	**Main Contact Phone (2)**

Email Address	**Preferred Language for Written Communications**

Employment Status of Person Responsible for Paying Bill

☐ Employed (date of hire): _____ ☐ Unemployed (how long): _____

☐ Self-Employed ☐ Student ☐ Disabled ☐ Retired ☐ Other: _____

Section C. Family Information

List all family members in your household, including you. Family includes people related by birth, marriage, or adoption who live together (for patients 18 and older: spouse, domestic partner, dependent children under 21 or any age if disabled; for patients under 18: parent, caretaker relatives, and other dependent children under 21 or any age if disabled).

Total Family Size: _____ Attach additional page if needed.

Name	Date of Birth	Relationship to Patient	If 18 or older: Employer(s) or Source of Income	Gross Monthly Income (before tax)	Applying?
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N

Sources of Income to Disclose: All adult family members income must be disclosed. Examples: wages, unemployment, self-employment, workers compensation, disability, SSI, Social Security, child/spousal support, work-study, pensions, rental income, dividends, interest, and royalties.

Section D. Income Information

REMEMBER: You must include proof of income with your application. Documentation is limited to recent pay stubs or income tax returns. AHMC may accept, but does not require, other forms.

Acceptable Proof of Income

- W-2 withholding statement, OR
- Current pay stubs (within the last 3 months), OR
- Last year income tax return, including schedules if applicable, OR
- Written, signed statements from employers or others, OR
- Approval or denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

Section E. Expense Information (Optional)

This information is used only to help us set a fair payment plan if you qualify for reduced-price care. It is NOT used to determine whether you qualify for financial assistance.

Monthly Rent/Mortgage ($)	**Monthly Medical Expenses ($)**
Monthly Medical Insurance Premiums ($)	**Monthly Utilities ($)**
Other Monthly Debt/Expenses (child support, loans, medications, other) ($)	**Describe Other Expenses**

Section F. Important Notice - Assets Are NOT Considered

IMPORTANT: Under California law (AB 2297, effective January 1, 2025), AHMC does NOT consider your monetary assets in determining your eligibility for Charity Care or Discount Payment. You are NOT required to disclose the balances of checking, savings, retirement, or investment accounts to qualify.

ONLY if you are a Medicare beneficiary WITHOUT Medi-Cal coverage, AHMC may ask you for bank statements or similar source documentation, solely for Medicare cost-report purposes. For all other applicants, this information is optional and WILL NOT be used to determine eligibility.

Section G. Additional Information (Optional)

Please use the space below or attach an additional page if there is other information about your current financial situation that you would like us to consider, such as a recent financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss. This information is optional.

Section H. Homelessness Attestation (Optional)

If you are experiencing homelessness, you may check the box below. You do not need to disclose any other information to qualify for presumptive eligibility based on homelessness. AHMC may accept this attestation alone as a basis for Charity Care.

☐ I attest that I am currently homeless and have no permanent address.

Patient or Guarantor Initials: _____

Section I. Patient Agreement and Signature

I understand AHMC Healthcare, Inc. (AHMC) may verify the income and family-size information I have provided. I understand that monetary assets, credit reports, and credit history will NOT be used to determine my eligibility for financial assistance.

I affirm that the information I have provided is true and correct to the best of my knowledge. I understand that providing false information may result in denial of financial assistance and that I may be responsible for services provided.

I understand AHMC Financial Assistance Program is a payer of last resort. I confirm any prior assignments of benefits and rights, including from liability actions, personal injury claims, settlements, and insurance benefits that may become payable for illness or injury, to AHMC or its subsidiaries providing care.

I understand that I may apply for financial assistance at any time. There is no deadline, and I may apply even if I have already paid my bill or my account has been sent to collections.

Signature of Person Applying	**Date**

For Office Use Only		
Family Size	**Gross Annual Family Income ($)**	**FPL Based on Family Size ($)**
Income as % of FPL	**Program (Charity Care / Discount Payment)**	**Approved Write-Off / Discount Amount ($)**
Account Number(s)	**Date of Service**	**Original Balance ($)**
Determination Date	**Approved / Denied**	**Reason (if denied)**
Prepared By / Title / Dept	**Examined By / Title / Dept**	**CFO Approval (if required)**

Presumptive Eligibility Flag: If any of the following apply, this applicant may qualify for presumptive eligibility without further documentation: homeless; enrolled in SNAP/CalFresh, TANF, WIC, SSI, or General Assistance; prior AHMC approval within 6 months; deceased with no estate; ward of state or foster youth.

☐ Presumptive eligibility applied. Basis: _____

How to Reach Us

Contact the Financial Counselor at the AHMC hospital where you received services, or use the centralized mailing address below.

Facility	Phone	Email
AHMC Anaheim Regional Medical Center	714-774-1450	pfs.ana@ahmchealth.com
AHMC Doctors Hospital of Riverside	951-688-2211	pfs.dhr@ahmchealth.com
AHMC Garfield Medical Center	626-573-2222	pfs.gmc@ahmchealth.com
AHMC Greater El Monte Community Hospital	626-579-7777	pfs.gem@ahmchealth.com
AHMC Monterey Park Hospital	626-570-9000	pfs.mp@ahmchealth.com
AHMC San Gabriel Valley Medical Center	626-289-5454	pfs.sgv@ahmchealth.com
AHMC Seton Medical Center	650-992-4000	pfs.set@ahmchealth.com
AHMC Seton Medical Center - Coastside	650-563-7100	pfs.sec@ahmchealth.com
AHMC Whittier Hospital Medical Center	562-945-3561	pfs.wht@ahmchealth.com

Centralized Mailing Address

AHMC Healthcare, Inc. - Financial Assistance

500 E Main Street, Alhambra, CA 91801

Attention: Director of CBO

Free Help with Your Application

Health Consumer Alliance: 1-888-804-3536 or https://healthconsumer.org

If You Believe You Were Wrongly Denied

California Hospital Bill Complaint Program: https://HospitalBillComplaintProgram.hcai.ca.gov