Charity Care and Discounted Payment Programs

Dameron Hospital recognizes that many of the patients it serves may be unable to access quality health care services without financial assistance. The Charity Care and Discounted Payment Policy was developed to ensure that the Hospital continues to uphold its mission of providing quality health care to the community, while carefully taking into consideration the ability of the patient to pay.

Eligible Services

Financial assistance provided to Hospital patients pursuant to the Charity Care and Discounted Payment Programs shall only apply to charges incurred for Medically Necessary Services.

General Eligibility

The Hospital shall determine eligibility for the Charity Care Program or Discounted Payment Program based upon an individual's financial need in accordance with the Charity Care Program and Discounted Payment Policy. Patients seeking Charity Care or Discounted Payment must make reasonable efforts to provide the Hospital with documentation of income and health benefits coverage. If a patient fails to provide information as is reasonable and necessary for the Hospital's eligibility determination, the Hospital may consider such failure in making its determination.

Application Procedures

Attached you will find a statement of financial conditions that must be filled out in its entirety. To be considered for Discounted Payment or Charity Care under the Policy, the patient must provide the Hospital with financial and other information needed to determine eligibility. This includes completing the required application forms and cooperating fully with the information gathering and assessment processes. The Hospital may, nonetheless, require waivers or releases from the patient or the patient's family authorizing the Hospital to obtain verifying information from financial or commercial institutions, or other entities that hold or maintain the monetary assets. A patient's failure to mail or otherwise deliver to the Hospital a complete Financial Assistance Application within 30 days of the patient's receipt of such application shall result in denial of the request for Discounted Payment or Charity Care. Subsequent requests for consideration will be processed at the sole discretion of the Hospital. Please return this application within 30 days, along with the following documents which support the data you entered on the application:

1. Proof of Identity – Provide one of the following:
   - Copy of state issued driver's license
   - Copy of Social Security card
   - Copy of Photo ID
2. Previous Year's Federal and State Income Taxes, if not available please explain why and attach copy of 2 most recent pay stubs
3. All Saving and Checking Account(s) Statements
4. Rent Receipts (if applicable)
5. Alimony (if applicable)

Emergency Physician Services

An emergency physician who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs. Please contact the emergency physicians billing office directly for further information regarding their financial assistance programs.

Please contact the Dameron Hospital Credit and Collections Coordinator at (209) 461-3147 between the hours of 7:00 a.m. to 3:30 pm if you have questions or need assistance in completing the attached Statement of Financial Condition application.

STATEMENT OF FINANCIAL CONDITION
SCHEDULE OF CURRENT INCOME AND EXPENDITURES

Your Name: ______________________ Spouse Name: ______________

Your SS# ______________________ Spouse SS#: ______________

Address: ____

City/State/Zip: ______________________ Phone: ________________

A. FAMILY STATUS

1. List all dependents that you support (other than your spouse)

Name	Age	Relationship

B. EMPLOYMENT AND OCCUPATION

1. You are employed by: ______________________ Position ________
   If self employed, give name of business ______________________

2. Your spouse is employed by: __________________ Position ________
   If self employed, give name of business ______________________

C. CURRENT INCOME

	You	Spouse
1. Gross pay (wages, salary, commissions, tips)	$__________	__________
2. Take home pay (gross pay less all deductions)	$__________	__________
3. Income from operating a business	$ __________	__________
4. Other income:		
a. Interest and dividends	$ __________	__________
b. From real estate or personal property	$ __________	__________
c. Social Security	$ __________	__________
d. Pension or other retirement income	$ __________	__________
e. Other (specify)__________________	$ __________	__________
______________________________	$ __________	__________
5. Alimony, maintenance or support payments	$ __________	__________
TOTAL MONTHLY INCOME (total all above)	**$** __________	__________

(PLEASE TURN OVER AND COMPLETE OTHER SIDE)

D. SCHEDULE OF CURRENT EXPENDITURES

1. Home expenses:
   - a. Rent or house payment and maintenance cost $ ___________
   - b. Household supplies $ ___________
   - c. Real estate taxes $ ___________
   - d. Utilities
     - Electric and gas $ ___________
     - Water $ ___________
     - Telephone $ ___________
     - Other (specify)________________ $ ___________

     Total Utilities $___________
2. Other Expenses:
   - a. Spousal or child support $___________
   - b. Insurance (only if not deducted from wages)
     - Health $ ___________
     - Auto $ ___________
     - Homeowners or renters $ ___________
     - Other (specify) ____________________ $ ___________

     Total Insurance Expenses $ ___________
   - c. Installment Expenses:
     - Auto $ ___________
     - Other (specify) ________________________ $ ___________
     - Other (specify) ________________________ $ ___________

     Total Installment Expenses $ ___________
   - d. Transportation (including gas & repairs) $ ___________
   - e. Education or child care $ ___________
   - f. Food $ ___________
   - g. Clothing (including laundry or cleaning) $ ___________
   - h. Medical, dental, and medicines $ ___________
   - i. Other (specify) ______________________________ $ ___________
     Other (specify) ______________________________ $ ___________

TOTAL CURRENT MONTHLY EXPENSES (Total all above) $ ___________

By my signature, I declare under the penalty of perjury that the above schedule of income and expenditures is a true reflection of my monthly income and expenses. I agree to allow Dameron Hospital Association to verify employment status and credit history for the purpose of determining my qualification for full or partial charity consideration.

____________________ ____

Date (Signature of Patient or Guarantor)