FINANCIAL ASSISTANCE APPLICATION

Charity Care and Discount Payment Assistance

Notice and Assistance

Use this application to ~~request~~ apply for Charity Care, ~~or~~ Discount Payment Assistance, or both. If you are unsure which program to request, contact the Business Office at (213) 314-1492 for free help. You may apply at any time before, during, or after hospital services. Patients who apply only for Discount Payment Assistance may receive less financial assistance than may be available under the Charity Care program.

Eligibility is based on Family Income and family size. Monetary assets are not considered. Do not provide bank account numbers, balances, investments, retirement accounts, home values, vehicle values, or other asset information. For documentation of income, the Hospital may request only recent paystubs or income tax returns. The Hospital may accept other forms of income documentation but will not require them.

Financial Assistance applies only to eligible hospital charges for Covered Services. It does not apply to charges from physicians or other providers who bill separately from the Hospital.

Charity Care is available to eligible Uninsured Patients with Family Income at or below 200% of the most recent Federal Poverty Guidelines. Patients with High Medical Costs whose Family Income is at or below 200% may also qualify for Charity Care, including patients with insurance coverage, when they otherwise meet the requirements of the Policy. Free language assistance and accessible formats, including braille, large print, audio, and accessible electronic formats, are available~~Charity Care is available to eligible Uninsured Patients with Family Income at or below 200% of the most recent Federal Poverty Guidelines. Discount Payment Assistance is available to eligible Uninsured Patients and eligible Patients with High Medical Costs whose Family Income is at or below 400% of the most recent Federal Poverty Guidelines.~~

~~Free language assistance and accessible formats, including braille, large print, audio, and accessible electronic formats, are available~~ by calling (213) 314-1492 or visiting the Business Office.

Program Requested

Select one: ☐ Charity Care ☐ Discount Payment Assistance ☐ Both / Unsure

Hospital Location

Select one: ☐ L.A. Downtown Medical Center ☐ West Covina Medical Center

Patient Information

Date of Service: _____

Patient Name: _____

Date of Birth: _____

Mailing Address: _____

City / State / ZIP: _____

Telephone Number: _____

Gender: ☐ Male ☐ Female ☐ Other / Prefer not to answer

Ethnicity - optional and not used to determine eligibility:

Ethnicity: ☐ White ☐ Black ☐ Hispanic/Latino ☐ Native American/Alaska Native

Ethnicity continued: ☐ Asian/Pacific Islander ☐ Other ☐ Prefer not to answer

Program, Insurance, and Family Size

Possible third-party payment source: ☐ Private Insurance ☐ Medi-Cal ☐ Medicare ☐ Self-Pay ☐ Other ☐ None

Primary income source: ☐ Employment ☐ Self-employment ☐ Social Security ☐ Disability ☐ Unemployment

Primary income source continued: ☐ Retirement/Pension ☐ Public Assistance ☐ Support ☐ Other ☐ None

You are not required to apply for other health coverage before the Hospital reviews this application for Discount Payment Assistance.

List the patient and family members included in family size.

Name	Relationship to Patient	Age	Gender

Family Income

List Family Income as monthly or annual income. Attach income documentation, if available.

Income Source	Monthly Amount	Annual Amount
Wages - Patient	$	$
Wages - Spouse / Domestic Partner	$	$
Wages - Other Family Members	$	$
Self-Employment / Farm Income	$	$
Public Assistance / Social Security / Disability	$	$
Unemployment / Workers' Compensation / Strike Benefits	$	$
Spousal Support / Child Support / Military Allotments	$	$
Pension / Retirement	$	$
Dividends, Interest, Rental Income, or Other	$	$

Income Documentation

Attach recent paystubs or recent income tax returns. If those are not available, attach other documents showing Family Income. Recent paystubs generally means paystubs within 6 months before or after the first hospital bill, or within 6 months of a pre-service application. Recent tax returns generally means returns for the year of the first hospital bill or the 12 months before the first hospital bill. Asset information is not required and will not be used.

Service and Account Information

Type of Service	Unit of Service	Amount / Description	Date
Hospital Inpatient	Inpatient Days	Billed Amount: $_____	
Hospital Outpatient	Outpatient Days	Payment Collected: $_____	
Other		Other Adjustments / Write-Offs: $_____	
Patient Responsibility		$_____	

Expenses - Optional

Expense information is not required for basic eligibility. It may be used to evaluate high medical cost eligibility, payment plan options, or other assistance.

Expense	Monthly Amount	Expense	Monthly Amount
Mortgage / Rent	$	Health Insurance	$
Utilities / Telephone	$	Medical Bills / Hospital / Physicians	$
Food	$	Medications / Auto Loans / Other	$

Asset Information Not Required

Monetary assets, bank references, account numbers, account balances, investment balances, retirement balances, real estate values, vehicle values, and other asset information are not required and will not be considered when determining eligibility for financial assistance.

Income Calculation - Hospital Use or Applicant Assistance

Calculation Item	Amount or Value
Total Monthly Gross Income	$
Minus Monthly Deductions, if applicable	$
Adjusted Monthly Net Income	$
Family Size	
FPL Percentage, if calculated	

Applicant Statement

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.

I agree to tell the provider within ten (10) days if there are changes in my income, expenses, household size, household members, or address.

I understand that the information I provide will be kept confidential as required by law.

I understand that asset information is not required and will not be used to determine eligibility for financial assistance.

Applicant / Authorized Representative Signature	Date

Hospital Review and Written Determination

The Hospital will review the completed application and provide a written eligibility determination.

If you disagree with the Hospital's determination, you may request review by the Hospital's Chief Financial Officer or designee. A written decision will be provided.

Decision: ☐ Approved ☐ Denied ☐ More Information Needed

Comments: _____

Reviewer Signature / Date: _____

Hospital Use Only

Eligibility must be based on Family Income and family size. Do not use monetary assets or other asset information. If the patient appears eligible for financial assistance or requests assistance, follow Hospital policy before referring the account to collections.

Questions or Complaint Information

For questions or help applying, contact the Business Office at (213) 314-1492. If you believe you were wrongly denied financial assistance, you may file a complaint with the State of California Hospital Bill Complaint Program at HospitalBillComplaint.hcai.ca.gov.