Canyon Ridge Hospital

Application for Discount or Charity

Solicitud de descuento o beneficencia

It is the policy of Canyon Ridge Hospital, in compliance with California State law AB774 (Hospital Fair Pricing Policies) to provide discounts from standard billed charges for all self pay and high medical cost patients as defined above. To determine if you are eligible for discount or charity, please complete the following information (the business office staff will assist in completion of the form if requested) **Please note:** If you are applying for discount payment only, you may receive less financial assistance than what may be available under charity care:

Es política de Canyon Ridge Hospital, según la ley estatal AB774 de California (Políticas de fijación de precios justos para hospitales), proporcionar descuentos en gastos estándares facturados para todos los pacientes que pagan por cuenta propia y pacientes con costos médicos elevados según se define a continuación. Para determinar si usted es elegible para un descuento o beneficencia, complete la siguiente información (el personal de la oficina comercial lo ayudará a completar el formulario si fuese necesario) Tenga en cuenta: si solicita pago con descuento únicamente, es posible que reciba menos asistencia financiera que la que puede estar disponible bajo atención caritativa:

When applying for a Discount, the facility may only require confirmation of income through either recent paystubs or income tax returns. To apply for Discount only, please complete Section 1. To apply for Charity Care, please complete both Section 1 and Section 2.

Al solicitar un descuento, es posible que el centro solo requiera confirmación de ingresos a través de talones de pago recientes o declaraciones de impuestos sobre la renta. Para solicitar el descuento únicamente, complete la Sección 1. Para solicitar Atención de caridad, complete la Sección 1 y la Sección 2.

Section 1 (For Discount and Charity Care):
Patient Name (Nombre del paciente): _____

Patient account # (Número de cuenta del paciente): _____

Guarantor Name (Nombre del garante): _____

Annual income (Ingreso annual): $_____
(Note: annual income must be supported by either a recent pay stub or your recent income tax return).
(Nota: el ingreso anual debe estar acompañado de un recibo de sueldo o su declaración de impuesto sobre las rentas más reciente).

Section 2 (For Charity Care ONLY):

Number of persons in family or household (Cantidad de personas de la familia o en la casa): _____

Out of pocket medical expenses during the previous 12 months (including an estimate of your out of pocket costs for this hospitalization) (Gastos médicos en efectivo durante los 12 meses anteriores (incluido un estimado de sus costos en efectivo para esta hospitalización)): _____

For completion by business office staff only.

1. Annual income _____
2. Federal Poverty Level (FPL) for family size _____
3. Line 1 as a percent of line 2 _____
4. Maximum payable by Medicare or Medi-Cal for stay _____

Insured patients only:

5. Expected out of pocket cost for this stay _____
6. Total out of pocket expenses-previous 12 months _____
7. Line 6 plus line 7 as a percent of line 1 _____

Assistance Type	Line 3 percent	Required Discount
High Medical Cost Patient Charity Care	Less than or equal to 400%	100%

Discount for insured patients to be applied to the stay based on the following grid:

Assistance Type	Line 3 percent	Required discount
Self Pay Discount	Greater than 500%	Lesser of applicable private pay discounted rate, or stated co-payment account.
Partial Discount	Between 401% and 500%	Equal to equivalent Medicare reimbursement.
Charity Care	Less than or equal to 400%	100%

Federal Poverty Guidelines as of 01/12/26 (Note: the figures below equal 100% of federal poverty levels):

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	**$15,960**	**$19,950**	**$18,360**
2	**21,640**	**27,050**	**24,890**
3	**27,320**	**34,150**	**31,420**
4	**33,000**	**41,250**	**37,950**
5	**38,680**	**48,350**	**4,480**
6	**44,360**	**55,450**	**51,010**
7	**50,040**	**62,550**	**57,540**
8	**55,720**	**69,650**	**64,070**
For each additional person, add	**5,680**	**7,100**	**6,530**

*A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.