JOHN MUIR HEALTH

5003 COMMERCIAL CIRCLE
CONCORD, CA 94520

John Muir Health is pleased to offer a program for our patients who need assistance in paying their medical bills. The program is entirely self-funded by John Muir Health as part of our core commitment to the community we serve. Please be aware that acceptance into the John Muir Health Patient Financial Assistance Program will not cover services of providers who are not employed directly by the medical center or for services that are provided outside of one of our hospitals. The program only covers accounts for hospital services rendered for which an initial bill has been provided to you over the last five months and does not automatically cover future services.

For your application to be considered, certain documents are required. Please provide the information as indicated below for yourself and any adults residing in your household who reports you on their Tax Returns or provides support to your living expenses, as the Financial Assistance Program is based on household income. If you are unable to provide the following information, please provide a written explanation.

Initial Qualifying Requirement:

☐Your household income must be below 400% of the Federal Poverty (FPL) guidelines based on members of the household. Please reference table below for income thresholds.

Family Size	1	2	3	4	5	6	7	8	9	10
400% of FPL	$58,320	$78,880	$99,440	$120,000	$140,560	$161,120	$181,680	$202,240	$222,800	$243,360

Documentation Requirements:

- ☐ Current signed Tax Return **or** most recent W-2 and previous year signed Tax Returns, if current taxes are not filed
- ☐ Copy of pay stubs for the last two pay periods
- ☐ Proof of rent / mortgage payments for the past three months
- ☐ Most recent statements for all investment accounts
- ☐ The last three months bank statements, all pages – checking and savings
- ☐ School Transcript and Financial Assistance if applicable

<u>In addition, if you do not have insurance:</u>

- ☐ The patient is required to apply for medical coverage through Covered California (888) 975-1142, if over 18 years old, and provide a copy of the determination letter indicating whether applicant denied or is eligible for a program. Attach a copy of the insurance card if applicable.
- ☐ If the patient is a minor or is supporting minor children, patient is required to apply for Medi-Cal (800) 709-8348 and provide a copy of the determination letter indicating whether denied or eligible for a program.

<u>In addition, if you have insurance:</u>

- ☐ Proof that your medical expenses (includes all considered in your household) have exceeded the lesser of 10% of your household family income in the past 12 months of application or your current family income.

We must receive this information within 30 days of this letter. NOTE: If your signed application and completed information is not received by the due date listed, John Muir Health is unable to consider your request for assistance and application will be denied.

If you have any questions, please contact our Customer Service Department at: (925) 947-3336.

Thank You.

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1. PATIENT INFORMATION		
Last Name	**First Name**	**DOB:**

2. APPLICANT INFORMATION	Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other		Marital Status ☐Married ☐Single	
Last Name	**First Name**		**Date of Birth**	**Social Security Number**
Street Address (No PO Boxes)	**City**	**State**	**County**	**Zip**
How long at this address?	**Are you currently employed?**			**How long?**
Home Phone	**Cell Phone**			**Other Contact**

3. GENERAL INFORMATION				
Does the patient have a Legal Conservator? ☐Yes ☐No (If yes, please provide the Conservator information below)				
Last Name	**First Name**		**Relationship to Patient** ☐Self ☐Spouse ☐Parent ☐Other _____	
Street Address	**Apt/Ste**	**City**	**State**	**Zip**

4. FAMILY AND LIVING ARRANGEMENT INFORMATION
(For the person financially responsible for the account, if different than the patient)

Including yourself, how many people live in your household? _____
How many household members contribute to your finances? _____

Do you own your home? ☐Yes ☐No
Are you living in the residence of your parent or another adult? ☐Yes ☐No
Do you pay rent? ☐Yes ☐No Amount of rent per month? _____

How do you pay your mortgage/rent? _____
Do you exchange work for rent/living expenses? ☐Yes ☐No
Please explain:_____

Do you receive all or some financial support from any adult members of the residence?
☐Yes ☐No

Are you receiving any of the following types of financial support? Please check all that apply.
☐Living expenses
☐Medical bills
☐Other _____
Estimated total amount of financial support: $_____/month or $_____/ year

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Do you currently receive financial assistance for attending school? ☐Yes ☐No
Total amount of financial support: $_____/semester or $_____/ year

Do you currently receive government support? Please check all that apply.
☐Food Stamps ☐Housing Assistance ☐Payment of work injury
☐Disability ☐Welfare/WIC
☐Other (please specify): _____

Does your parent or guardian claim you as a dependent on their income tax? ☐Yes ☐No

Did you file taxes last year? ☐Yes ☐No
Was your adjusted gross income less than $12,550? ☐Yes ☐No

5. EMPLOYMENT AND HEALTH INSURANCE INFORMATION
(For the patient on the account)

Are you currently employed or were you employed at the time you had your medical service?
☐Yes ☐No
Does your employer offer Health Insurance to its employees? ☐Yes ☐No
Are you covered by this health insurance? ☐Yes ☐No
If no, please explain why. _____

Is your spouse/domestic partner (or parent, if patient is a minor) currently employed or was employed at the time you had your medical service? ☐Yes ☐No
Does your spouse/domestic partner's (or parent, if patient is a minor) employer offer Health Insurance to its employees? ☐Yes ☐No
Are you covered by this health insurance? ☐Yes ☐No
If no, please explain why. _____

6. OTHER PROGRAMS
(For the patient on the account)

Have you applied for any of the following programs listed below within the last 12 months of this application? Please check any programs that apply.
☐Medi-Cal ☐Healthy Families ☐Medicare ☐Basic Adult Care
☐Victims of Violent Crime ☐State Disability

7. INCOME ASSETS
(For the person financially responsible for the account, if different than the patient)

Do you have/own any of the following? (Mark all that apply to you)
☐Home ☐Rental Property ☐Checking Account ☐Savings Account
☐Credit Cards ☐Investment Account ☐Stocks/Bonds ☐Safe Deposit Box

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8. SUPPORTING DOCUMENTATION
(REQUIRED FOR ALL ADULTS LIVING IN HOUSEHOLD THAT CONTRIBUTE TO YOUR FINANCES)

Application may be denied if all documents are not provided. If a document is unavailable, please explain why.

- Copy of signed Income Tax Return (1040 Form) that was last filed for every member of your household who filed taxes.
- Current pay stubs (last two pay periods)
- Proof of rent / mortgage payments for the past three months
- Most recent statements for all investment accounts
- The last three months bank statements, all pages – checking and savings
- School Transcript and Financial Assistance (if applicable)
- Copy of Social Security, Disability, Pension and/or Unemployment allotment letter (if applicable).
- Copy of Child Support court order or deposit slip (if applicable)

9. COMMENTS

Enter any additional information you want to state that is not reflected on this application.

10. SIGNATURE AND DATE (REQUIRED OF APPLICANT)

I certify that all information is true and complete, and hereby authorize John Muir Health to request a credit report and/or verify any of the above information as deemed necessary. I understand that incomplete applications, including an application missing a signature, may be denied. I agree to notify John Muir Health of any changes to my financial circumstances that may affect my eligibility for financial assistance.

Applicant Signature

_____

Date

_____

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PLEASE RETURN APPLICATION AND ALL INFORMATION TO:

JOHN MUIR HEALTH
5003 COMMERCIAL CIRCLE
CONCORD, CA 94520
ATTN: SINGLE BUSINESS OFFICE

Your completed Patient Assistance Application along with the requested documentation must be returned by

30 days of receipt of this letter

Please remember to complete the entire application and send it with all the required documents that are listed in the cover letter.

Incomplete applications may not meet the qualification requirements of the program.

If your application and documents are not received by the above date, it will be assumed you have decided not to continue with your application, and it will be closed.

Please contact Customer Service at 925-947-3336 if you:

- **Have any questions about the application**
- **Need assistance completing your application**
- **Need more time to complete your application**