Status **Active** PolicyStat ID **15839998**

Origination	1/18/2021	Policy Area	FN: Finance
Last Approved	5/24/2024	Policy #S	FN 13.074
Last Revised	3/24/2022		

Financial Assistance to Patients

COPY

PURPOSE:

Fresno Surgical Hospital (FSH) is committed to providing high quality, comprehensive health care service to our patient community. This includes those who are unable to pay as well as those whose limited means make it extremely difficult to meet the health care expenses incurred. Fresno Surgical Hospital is committed to:

- Provide access to quality health care services with compassion, dignity and respect for those we service;
- Provide caring for all persons, regardless of their ability to pay for services; and
- Assisting patients who cannot pay for part or all of the care that they receive.

Fresno Surgical Hospital honors the dignity of every person, complies with applicable Federal civil rights laws, and does not discriminate on the basis of protected classes, including but not limited to, race, color, national origin, age, disability, or sex. Free aids and services to people with disabilities are available as well as free language services to people whose primary language is not English.

PROCEDURE:

This Financial Assistance to Patients (FAP) procedure is designed to address the patients' need for financial assistance as they seek services through Fresno Surgical Hospital (FSH). It applies to all eligible services as provided under applicable state or federal law. Eligibility for financial assistance and support will be determined on an individual basis using specific criteria and evaluated on an assessment of the patient's and/or family's health care needs, financial resources and obligations.

I. Qualifying Criteria for Financial Assistance

a. Services eligible for Financial Assistance:

i. All services needed for the prevention, evaluation, diagnosis or treatment of a medical

condition and not mainly for the convenience of the patient or medical care provider.

ii. Emergency medical care services will be provided to all patients who present to the hospital, regardless of the patient's ability to pay.

b. Services not eligible for Financial Assistance:

i. Cosmetic services, infertility treatments and other elective procedures and services that are not medically necessary.

ii. Services not provided and billed by FSH (e.g. independent physician services, private duty nursing, ambulance transport, retail medical supplies, surrogacy services, pathology, laboratory, etc.)

iii. FSH may exclude services that are covered by an insurance program at another provider location but are not covered at Fresno Surgical Hospital after efforts are made to educate the patients on insurance program coverage limitations and provided that federal Emergency Medical Treatment and Active Labor Act (EMTALA) obligations are satisfied.

iv. Medi-cal or other public assistance programs' Share of Costs are considered an important part of those Government Programs. Financial Support cannot be applied to Share of Cost balances.

c. Applying for Financial Assistance:

- Fresno Surgical Hospital will make FAP applications available as part of the intake or discharge process as well as in the patient registration lobby areas and billing office. Documents will also be made available in the primary language of the local population that constitutes more than 5 percent of the residents of the community, or over 1,000 persons served by FSH.
- Applications can also be downloaded from the FSH website or sent by mail by contacting the billing office listed on the website.
- Patient Accounting Representatives are available to assist with the completion of the application. Language support is available as needed by patients.
- FSH will take measures to notify members of the community served by FSH about the FAP. Such measures may include: the distribution of information sheets summarizing the FAP to local public agencies and nonprofit organizations that address the health needs of the community's low income populations.
- FSH will provide patients with a written notice that indicates financial assistance is available for eligible patients, identifies the Extraordinary Collection Actions (ECA) that FSH (or other authorized party) intends to initiate to obtain payment for the care, and states a deadline after which such ECA may be initiated that is no earlier than 30 days after the date that the written notice is provided. FSH will include a plain language summary of the FAP with the written notice and make a reasonable effort to orally notify the patient about the Fresno Surgical Hospital FAP and about how the patient may obtain assistance with the FAP application process.
- In the case of deferring or denying, or requiring a payment for providing medically necessary

care due to an individual's nonpayment of one or more bills for previously provided care covered under the Fresno Surgical Hospital FAP, FSH may notify the individual about its FAP less than 30 days before initiating the ECA. However, to avail itself of this exception, FSH must satisfy the following conditions:

Provide the patient with a FAP application form (to ensure the patient may apply immediately, if necessary). The patient is to be notified in writing about the availability of financial assistance for eligible individuals and the deadline, if any, after which the hospital will no longer accept and process a FAP application submitted by the patient for the previously provided care at issue. This deadline must be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement for the previously provided care was provided. Thus, although the ECA involving deferral or denial of care may occur immediately after the requisite written notice is provided, the patient must be afforded at least 30 days after the notice to submit a FAP application for the previously provided care.

Notify the patient about the FAP by providing a plain-language summary of the FAP and by orally notifying the patient about the hospitals FAP and about how the patient may obtain assistance with the FAP application process.

Process the application on an expedited basis, to ensure that medically necessary care is not unnecessarily delayed if an application is submitted.

The modified reasonable efforts discussed above are not needed in the following cases:

- If 150 days have passed since the first post-discharge bill for the previously provided care and FSH has already notified the patient about intended ECA.
- If FSH has already determined whether the patient was FAP-eligible for the previously provided care at issue based on a complete FAP application or had presumptively determined the patient was FAP-eligible for the previously provided care.

Completed applications, along with supporting documentation to determine household size and family income, are to be returned to FSH and/or mailed to the address on the application within the prescribed time.

Once the completed application is received, processing and determination of financial application may take up to 30 days.

d. Documentation for Establishing Income:

i. Information provided to FSH by the patient and/or family should include earned income, including monthly gross wages, salary and self-employment income; unearned income including alimony, retirement benefits, dividends, interest and income from any other source (e.g., food stamps); monetary assets, including savings and invest accounts excluding retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans for all dependents in the household; the number of dependents in the household and other information requested on the FAP application.

The first $10,000 of monetary assets shall not be counted in determining eligibility, nor shall 50% of monetary assets over the first $10,000 be counted in determining eligibility.

ii. Supporting documents such as payroll stubs, tax returns, P&L statements and bank statements will be requested to support information reported and shall be maintained with the completed application and assessment. FSH may not deny financial assistance based on the omission of information or documentation that is not specifically required by the FAP or FAP application form.

iii. FSH will provide patients that submit an incomplete FAP application a written notice that describes the additional information and/or documentation that must be submitted within 30 days from the date of the written notice to complete the FAP application. The notice will provide contact information for questions regarding the missing information. FSH may initiate ECA if the patient does not submit the missing information and/or documentation within the 30 day resubmission period and it is at least 150 days from the date FSH provided the first post-discharge billing statement for the care. FSH must process the FAP application if the patient provides the missing information/or documentation during the 240-day application period (or, if later, within the 30-day resubmission period.)

e. Presumptive Assistance:

FSH recognizes that not all patients are able to provide complete financial information. Therefore, Fresno Surgical Hospital may also engage outside resources to aid in the identification of those patients who are without the resources to pay for healthcare services. When such approval is granted it is classified as "Presumptive Assistance."

i. The predictive model is one of the reasonable efforts that will be utilized by FSH to identify patients who may qualify for financial assistance prior to initiating collection actions, i.e. write-off of a patient account to bad debt and referral to collection agency. This predictive model enables Fresno Surgical Hospital to systematically identify financially needy patients.

ii. Examples of presumptive cases include the following:

- Deceased patients with no known estate
- Homeless patients
- Non-covered medically necessary services provided to patients qualifying for public assistance programs (e.g., non-emergent services for patients with emergent only coverage)
- Patients currently receiving public assistance (e.g., food stamps)
- Patient bankruptcies
- Members of religious organizations who have taken a vow of poverty and have no resources individually or through the religious order.

iii. For patients who are non-responsive to the FAP application process, other sources of information, if available, should be used to make an individual assessment of financial need. This information will enable FSH to make an informed decision on the

COPY

financial need of non-responsive patients.

iv. For the purpose of helping financially needy patients, a third-party may be utilized to conduct a review of patient information to assess financial need prior to referral to collection or write-off to bad debt. This review utilizes a health care industry recognized, predictive model that is based on public record databases. These public records enable FSH to assess whether the patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process. In cases where there is an absence of information provided directly by the patient, and after efforts to confirm coverage availability are exhausted, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.

v. In the event a patient does not qualify under the predictive model, the patient may still provide supporting information within the established timelines and be considered under the traditional financial assistance application process.

vi. Patient will be notified of their approval for assistance. Patient who receive less than the most generous assistance levels may appeal within 30 days of the notice. The determination of a patient being eligible for less than the most generous assistance is based on presumptive support status or a prior FAP eligibility determination. Additionally, FSH may initiate or resume ECA if the patient does not apply for more generous assistance within 30 days of notification if it is at least 150 days from the date FSH provided the first post-discharge billing statement for the care. FSH will process any new FAP application that the patient submits by the end of the 240-day application period or, if later, by the end of the 30-day period given to apply for more generous assistance.

f. Timeline for Establishing Financial Eligibility-Application Period:

i. Every effort should be made to determine a patient's eligibility for financial assistance prior to or at the time of admission or service. The application period begins the day that care is provided and ends the later of 240 days after the first post-discharge billing statement to the patient or one of the following:

- The end of the period of time that a patient is eligible for less than the most generous assistance available, based upon presumptive support status or a prior FAP eligibility determination, and who has applied for more generous financial assistance; or
- The deadline provided in a written notice after which ECA may be initiated. FAP applications will be accepted any time during the application period. The award of financial assistance based on submission of a *completed application* will be in effect for the accounts identified on the FAP application that are within the application period and six months forward from the date of the signed FAP application. The award of financial assistance based on *presumptive support* status is limited to the accounts that are within the application period and only for the date(s) of service for the account(s) reviewed if no application is received. The hospital may require pre-approval for planned surgeries and/or re-verify qualifications at any time. FSH may accept and process an individual's FAP application submitted outside of the application period

on a case-by-case basis as authorized by the established approval levels. Accounts may be referred to a collection agency for initial processing prior to the completion of the application period.

ii. FSH (or other authorized party) will refund any amount the patient has paid for care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible patient, unless such excess amount is less than $5 (or such other amount set by notice or other guidance published in the Internal Revenue Bulletin). The refund of payments is only required for the episodes of care to which the FAP application applies.

iii. Determination for financial assistance will be made after all efforts to qualify the patient for governmental financial assistance or other programs have been exhausted. Compliance with the process to attempt to gain assistance with a government program may be requested to be considered eligible for financial assistance eligibility. A patient will not be denied eligibility if they are making a reasonable effort to obtain private or public health insurance.

iv. FSH will make every effort to make a financial assistance determination in a timely fashion. If other avenues of assistance are being pursued, FSH will communicate with the patient regarding the process and expected timeline for determination and shall not attempt collection efforts while such determination is being made.

v. Once qualification for financial assistance has been determined, reviews for continued eligibility for subsequent services should be made after a reasonable time period as determined by FSH.

g. Level of Financial Assistance:

i. FSH will follow the income guidelines established below in evaluating a patient's eligibility for assistance. A percentage of the Federal Poverty Guidelines (FPL), which is updated on an annual basis, is used for determining a patient's qualifications. However, other factors may also be considered such as the patient's financial status and/ or ability to pay as determined through the assessment process.

ii. Family Income at or below 200% of the Federal Poverty Level Guideline:

- A 100% discount for all patient balances will be provided for patients whose family income is at or below 200% of the most recent FPL.

iii. Family Income between 201% and 400% of the Federal Poverty Level Guideline:

- A discount off of total charges equal to the then-current Medicare reimbursement for the same/similar procedure.
- Patients whose income is at or below 400% of the FPL and have annual out of pocket costs at the hospital in excess of 10% of their current family income or family income in the prior 12 months, will be granted additional assistance.
- Patients whose account(s) are partial charity, the balance on the account must be offered interest-free payment arrangements. Patients with whom satisfactory payment agreements cannot be reached during the negotiation process, a payment plan will be established

consisting of monthly payments that do not exceed 10% of the patient's familial monthly income excluding deductions for "essential living expenses". Essential living expenses are defined as rent or house payments (including maintenance expenses), food and household supplies, utilities and telephone, clothing, child and spousal support, transportation and automobile expenses (including insurance, fuel and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses.

iv. Medically Indigent Support / Catastrophic: Financial Assistance is also available for medically indigent patients. Medical indigence occurs when a person is unable to pay some or all of their medical bills because their medical expenses exceed a certain percentage of their family or household income (for example, due to catastrophic costs or conditions), regardless of whether they have income that otherwise exceed the financial eligibility requirements for free or discounted care under the FSH FAP. Catastrophic costs or conditions occur when there is a loss of employment, death of primary wage earner, excessive medical expenses or other unfortunate events. Medical indigence / catastrophic circumstances will be evaluated on a case-by-case basis that includes a review of the patient's income and expenses. If an insured patient claims catastrophic circumstances and applies for financial assistance, medical expenses for an episode of care that exceed 20% of income will qualify the insured patient's co-pays, deductibles, and co-insurance payments to qualify as catastrophic charity care. Discounts for medically indigent care for the uninsured will not be less than FSH then-current Medicare payment for the same/similar services provided or an amount to bring the patient's catastrophic medical expense to income ratio back to 20%.

v. While financial assistance should be made in accordance with FSH's established written criteria, it is recognized that occasionally there will be a need for granting additional assistance to patients based upon individual considerations. Such individual considerations will be approved by the Chief Financial Officer and/or Chief Executive Officer.

II. Assisting Patients Who May Qualify for Coverage

a. FSH will make affirmative efforts to help patients apply for public and private programs for which they may qualify and that may assist them in obtaining and paying for health care services. Patients will be referred to local consumer assistance centers housed at legal offices for assistance with the application process.

b. FSH will have understandable, written procedures to help patients determine if they qualify for public assistance programs or the FAP.

III. Implementation of Accurate and Consistent Policies

a. Representatives from the Patient Accounting department will educate staff members who work closely with patients (billing and collections; patient registration; etc.) about billing, financial assistance, collection policies and practices, and treatment of all patients with compassion, dignity and respect regardless of their insurance status or their ability to pay for services.

b. FSH will honor financial assistance commitments that were approved under previous

guidelines. At the end of that eligibility period, the patient may be re-evaluated for financial assistance using the guidelines established in this procedure.

IV. Other Discounts

a. Self-Pay Discounts: FSH will apply a standard uninsured discount off of charges for all registered self-pay patients that do not qualify for financial assistance, based on a percentage of the then-current Medicare reimbursement rate for the same/similar procedure.

b. Additional Discounts: Adjustments in excess of the percentage discounts described in this procedure may be made on a case-by-case basis upon an evaluation of the age and collectability of the account and authorized by FSH's established approval levels.

Definitions:

Application Period - The period of time beginning the day that care is provided and ends the later of 240 days after the first post-discharge billing statement is provided to the patient or either of the following:

i. The end of the 30-day period that patients who qualified for less than the most generous assistance available based upon presumptive support status or prior FAP eligibility are provided to apply for more generous assistance.

ii. The deadline provided in a written notice after which ECA may be initiated.

Discounted Care - A partial discount off the amount owed for patients that qualify under the FAP.

Eligible Patient - An individual who meets the eligibility criteria described in this Policy, whether he or she is (1) uninsured; (2) receives coverage through a public program (e.g., Medicare, Medi-Cal or subsidized health care coverage purchased through a health information exchange), or (3) an insured patient with co-pay, deductible, and co-insurance amounts.

Emergent - Medical services are those needed for a condition that may be life threatening or the result of a serious injury and requiring immediate medical attention. This medical condition is generally governed by the Emergency Medical Treatment and Active Labor Act (EMTALA).

Extraordinary Collection Actions ("ECA") - Collection actions taken by FSH (or a collection agency on their behalf) include the following actions:

- Deferring or denying, or requiring a payment before providing, medically necessary care because of a patient's nonpayment of one or more bills for previously provided care covered under the hospital facility's FAP.
- Reporting outstanding debts to credit bureaus.
- Pursuing legal action to collect a judgment (i.e., garnishment of wages, debtor's exam).
- Placing liens on property of individuals.

Family (as defined by the U.S. Census Bureau) - A group of two or more people who reside together and who are related by birth, marriage or adoption. If a patient claims someone as a

dependent on their income tax return, according to the Internal Revenue Service rules, they may be considered a dependent for the purpose of determining eligibility under the FAP.

Family Income - A person's Family Income includes the income of all adult family members (related by birth, marriage or adoption in the household. For patients under 18 years of age, family income includes that of the parents and/or step-parents or caretaker relatives' annual income from the prior 12-month period or the prior tax year as shown by recent pay stubs or income tax returns and other information. Proof of earnings may be determined by annualizing the year-to-date family income, taking into consideration the current earnings rate or using previous year's tax returns.

Federal Poverty Guidelines ("FPG") - Guidelines which establish the levels of annual income for poverty as determined by the United States Department of Health and Human Services. These guidelines are updated annually in the Federal Register.

Financial Assistance - Support (charity, discounts, etc.) provided to patients for whom it would be a hardship to pay for the full cost of medically necessary services provided by Fresno Surgical Hospital who meet the eligibility criteria for such assistance and who have exhausted public and private payor sources.

Financial Assistance Policy ("FAP") - A written Policy and Procedure that meets the requirements described in Section 1.501(r)-4(b).

Financial Assistance Policy ("FAP") Application - The form and accompanying documentation a patient submits to apply for financial assistance under Fresno Surgical Hospital's FAP. FSH may obtain information from an individual in writing or orally (or combination of both).

Homeless - Describes the status of a person who resides in one of the places or is in a situation described below:

- in places not meant for human habitation, such as cars, parks, sidewalks; or
- in an emergency shelter; or
- in transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters; or
- in any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution.

Income - Wages, salaries, salary and self-employment income, unemployment compensation, worker's compensation, payments from Social Security, public assistance, veteran's benefits, alimony, survivor's benefits, pensions, retirement income, regular insurance and annuity payments, income from estates and trusts, rents received, interest/dividends, and income from other miscellaneous sources.

Medical Necessity - Treatment, procedures and services as defined and documented in the State of California Medi-Cal provider manual.

Policy - A statement of the high-level direction on matters of strategic importance to Fresno Surgical Hospital or a statement that further interprets Fresno Surgical Hospital's governing

documents.

Plain Language Summary of the FAP - A written statement that notifies a patient that the hospital facility offers financial assistance under a FAP and provides the following additional information in language that is clear, concise, and easy to understand:

- A brief description of the eligibility requirements and assistance offered under the FAP.
- A brief summary of how to apply for assistance under the FAP.
- The location where the patient can obtain copies of the FAP and FAP application form.
- Instructions on how the patient can obtain a free copy of the FAP and FAP application form by mail.
- The contact information, including telephone number and physical location, of the hospital facility office or department that can provide information about the FAP and provide assistance with the FAP application process.
- A statement of the availability of translations of the FAP, FAP application form, and plain language summary of the FAP in other languages, if applicable.

Procedure - A document designed to implement a Policy or a description of specific required actions or processes.

Service Area - The list of zip codes comprising Fresno Surgical Hospital's surrounding market area that constitutes a "community of need" for primary health care services.

Underinsured - An individual who, despite having health care coverage, finds that the obligation to pay insurance premiums, copayments, coinsurance, and deductibles is such a significant financial burden that he or she delays or does not receive necessary health care service due to the out-of-pocket costs.

Uninsured Patient - An individual who is uninsured, having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medi-Cal, SCHIP and CHAMPUS), Worker's Compensation, or other third party assistance to cover all or part of the cost of care, including claims against third parties covered by insurance to which Fresno Surgical Hospital is subrogated, but only if payment is actually made by such insurance company.

Vulnerable - Those persons whose health and well-being are considered to be more at-risk than the general population due to socioeconomic status, illness, ethnicity, age or other disabling factors.

References:

- Patient Protection and Affordable Care Act: Statutory section 501(r), Public Law
- Internal Revenue Service, Instructions for Schedule H (Form 990)
- Department of Treasury, Internal Revenue Service, Additional Requirements for Charitable Hospitals; Final Rule: Volume 79, No. 250, Part II, 26 CFR, Part 1
- State of California AB774 (Chapter 755, Statutes of 2006; also called the Hospital Fair Pricing

Policies Law)

- Federal Register and the Annual Federal Poverty Guidelines
- IRS Code, 26 CFR Parts 1 and 53 and 1545-BL58 Additional Requirements for Charitable Hospitals
- Catholic Health Association of the United States - A Guide for Planning & Reporting Community Benefit

Attachments

Federal Poverty Level (FPL) and Charity Adjustment Guidelines

Financial Assistance to Patients Application

Nondiscrimination and Accessibility Requirements

Approval Signatures

Step Description	Approver	Date
BOM FINAL	Managers Board of: Executive Assistant	5/24/2024
MEC	Committee Medical Executive [AF]	5/24/2024
DMC	Document Management Committee [CG]	5/24/2024
Policy Owner	Jim Rodriguez: Chief Financial Officer	5/16/2024

Thank you for your interest in our Financial Assistance Program. If you and/or a family member have applied for financial assistance at Fresno Surgical Hospital within the last six (6) months, please contact our office at (559) 447-7735 before completing this application.

Please return the completed application and all applicable documents listed below within thirty (30) days:

- **Three (3) months complete, itemized bank statements for all checking, savings, and/or investment accounts showing deposits and withdrawals. Please provide explanation for all deposits. (Required)**

- **Proof of earned and/or unearned income as documented below. (Required)**

1. Three (3) recent pay stubs for yourself, spouse and all dependents showing pay rate and hours worked OR
2. Current, or most recently filed, federal tax return for yourself and spouse OR
3. Contribution statement from family/friends stating how living expenses are being met AND
4. Any of the following documents, as applicable for yourself, spouse and all dependents:
    - Most recent tax return including Profit/Loss statement if self-employed
    - Most recent tax return for verification of dependents
    - Unemployment benefits statement
    - Student financial aid award letter
    - Determination letter for public assistance (e.g., CalFresh, Medi-Cal, etc.)
    - Social Security and/or Social Security Disability award letter or check
    - Dividend, interest and income from any other source (e.g., rental income, alimony income, retirement benefits, etc.).

If you are unable to provide any of these documents, please provide a letter of explanation as to why the documents were not returned.

Please return the financial assistance application and supporting documents to:

Fresno Surgical Hospital
Business office
6121 N Thesta Suite #101
Fresno, Ca 93710

Please allow approximately 30 days for processing once we have received a completed application. If you have any questions or require information in another language, please contact our office at the number listed below.

Sincerely,

Fresno Surgical Hospital
Customer Service
(559) 447-7735

NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

Fresno Surgical Hospital, honor the sacredness and dignity of every person, complies with applicable Federal Civil Rights laws, and does not discriminate on the basis of protected classes, including but not limited to, race, color, national origin, age, disability or sex.

Fresno Surgical Hospital: Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language and interpreters services through video and audio interpreter system network.
- Written information in other formats such as large print, audio, accessible electronic and other formats.

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters services
- Information written in other languages

If you need these services, please contact us at (559) 447-7735

If you believe that Fresno Surgical Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance in person, by mail, fax or email to:

Fresno Surgical Hospital, Attn:
Risk Management
6125 N Fresno Street
Fresno, Ca 93710
559-436-3406
Email: cqo@fshosp.com

You can also file a civil rights complaint with the US Department of Health & Human Services, Office of Civil Rights electronically via web, by mail or phone to:

Department of Health & Human Services 200
Independence Avenue, SW, Room a509F,
HHH Building, Washington, DC 20201
Web https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Phone 1-800-368-1019 TTY 1-800-537-7697

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-559-447-7735

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-559-447-7735

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-559-447-7735

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-559-447-7735.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.)번으로 전화해 주십시오. 1-559-447-7735.

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-559-447-7735.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните . 1-559-447-7735.

Hindi

ध्यान द�: य�द आप �हद� बोलते ह �तो आपके ि◌लए मुफ्त म� भाषा सहायता सेवाएं उपलब्ध ह।) पर कॉलकर� ।1-559-447-7735.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます）まで、お電話にてご連絡ください。1-559-447-7735.

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-559-447-7735.

Panjabi

ਿ◌ਧਆਨ ਿ◌ਦਓ: ਜੇ ਤੁਸ� ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ� ਭਾਸ਼ਾ ਿ◌ਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।) ਤੇਕਾਲ ਕਰੋ। 1-559-447-7735.

Portugese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para . 1-559-447-7735

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-559-447-7735

Farsi

هجوت: اگر هب نابز یسراف وگتفگ یم دینک، تالیهست ینابز تروصب ناگیار یارب امش
1-559-447-7735دیریگب سامت اب .دشاب یم مهارف

Cambodian

ប្រយ័ត៖ បើសិនអកនិយ ខែ, សជំនួ
យផក ឥតគិចនសំប់បំរអក។ ចូរ ទូរស័ព ។ 1-559-447-7735

Thai

เรียน: ถ้าคณ พดภาษาไทยคณสามารถใช้บริการชว่ ยเหลือทางภาษาได้ฟรี โทร 1-559-447-7735

Lao

ໂປດຊາບ: ຖ້ າວ່ າ ທ່ ານເວົ້ າພາສາ ລາວ, ອດ້ ານພາສາ, ໂດຍບໍ່ເສັ ງຄ່ າ, ການບໍລິການຊ່ ວຍເຫືຼ

ແມ່ ນມີພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1-559-447-7735.

Arabic

1 مقرب لصتا .ناجملاب كل رفاوتت ةيوغللا ةدعاسملا تامدخ نإف ،ةغللا ركذا ثدحتت تنك اذإ :ةظوحلم - (
.- مكبلاو مصلا فتاه: 1-559-447-7735.

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-559-447-7735.

Samoan

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-559-447-7735.

Hawaiian

E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo [hoʻokomo ʻōlelo], loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā : 1-559-447-7735.

CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE

Professional services provided by affiliated physicians or other providers may be billed separately. Application of Financial Assistance is at the discretion of those providers in accordance with their policies, procedures, and applicable regulations. The information provided in this application may be provided to affiliated providers to assist the patient. Fresno Surgical Hospital honors the sacredness and dignity of every person, complies with applicable federal and state laws, and does not discriminate on the basis of protected classes, including but not limited to, race, color, national origin, age, disability or sex.

Patient Name		Date of Birth	
Street Address		Telephone	Message Phone
City/State/Zip		Social Security Number	
Mailing Address (if different) or email if preferred			

Please provide the following information for yourself (if not the patient), spouse and dependents:

Name	SSN	Date of Birth	Relationship to Patient

Please list all account numbers and/or dates of service to be considered for financial assistance:

Patient Name	Account #	Date of Service	Medical Balance

Healthcare Marketplace Status

Have you applied for Insurance?	□ No	□ Yes	If Yes, Name/ID
If Yes, did you apply through:			□ Medicaid - State □ Health Exchange/ Healthcare.gov □ Other ____________________
Were you approved for an insurance plan?	□ No	□ Yes	
Have you enrolled and paid the premium for an insurance plan?	□ No	□ Yes	

Monetary Assets

Checking Account Balance	Bank:	$
Savings Account Balance	Bank:	$

Employment

Person Employed	Employer	Gross Pay Period	# of Pay Periods	Annual Gross
		$		$
		$		$
		$		$
		$		$

Other income Source	**Monthly**	**Annually**
Alimony	$	$
Public Assistance Program Type_______________(e.g., Cash, Food Stamps, etc.)	$	$
Payment from Retirement Plan	$	$
Social Security / Social Security Disability	$	$
Unemployment or Worker's Comp No. of Weeks:__________ Start Date:_________End Date:_________ Per Week $:______________	$	$
Other Income (Stocks/Bonds/Annuities/Interest/Rental Property)	$	$
Other Income (from family, friends, church, etc…)	$	$

VERIFICATION OF INCOME AND IDENTIFICATION

If we need additional information, you will be notified by telephone, US Mail or e-mail.

I certify that all information is true and complete to the best of my knowledge. I understand that the information provided will be verified and treated as personal and confidential. I authorize the release of any and all information from the California Department of Health Care Services. **I understand that I must provide verification of income, expenses, dependents, bank statements, pay vouchers and tax statements if applicable.** I also understand that I will be liable for payment of any services rendered at Fresno Surgical Hospital if the above information is given under false pretenses. I know that I am asking for financial assistance from Fresno Surgical Hospital only and not from other health care providers or physicians.

SIGNATURE: ______________________________ **DATE:** ______________

SPOUSE SIGNATURE (if applicable) ______________________________ **DATE:** ______________