Hospital Financial Assistance and Charity Care Application

Please fill out all information completely. If it does not apply, write N/A.

I received services at:		
☐ Highland Hospital ☐ San Leandro Hospital ☐ Alameda Hospital ☐ Fairmont Hospital		
Patient Information		
Account Number(s):		
Name:	Telephone Number:	
Address:		
City:	State:	Zip:
Applicant (Guarantor) Information		
Relationship to patient: ☐ Self ☐ Parent/Guardian		
Name:		Date of birth:
SSN:	Telephone Number:	
Address:		
City:	State:	Zip:
Employment Status:	Employer Name:	
Address:		
City:	State:	Zip:
Employer Telephone Number:		
Marital Status:		
Number of Dependents:	Age(s) of Dependents:	
Annual Family Income:		*(Income documentation is required)*
Spouse Information		
Name:	Employer Name:	
Employer Address:		
City:	State:	Zip:
Employer Phone Number:		
Additional Information		
Are you eligible for coverage with a Commercial Health Insurance? If yes, please provide the name of your Health Insurance, Phone Number and Identification Number:	☐ Yes	☐ No
Are you eligible for coverage with Medicare? If yes, please provide the scope of your coverage (A, B or both) and your identification number:	☐ Yes	☐ No
Are you eligible for coverage with Medi-Cal or any other state medical assistance program? If yes, please provide the County of coverage and your identification number:	☐ Yes	☐ No

Is your treatment related to an injury covered by Workers Compensation? If yes, please provide the name of the Workers Compensation Carrier and your claim number:	□ Yes	□ No
Is your treatment covered by Third Party Liability? (such as a car accident of slip and fall)? If yes, please provide the name of the auto carrier and your claim number:	□ Yes	□ No
Is your treatment a result of you being a victim of a crime incident? If yes, please provide the name of your Case Worker and your case number	□ Yes	□ No

Charity Care is being requested for: (Please complete all that apply)

Total charges on patient account(s) (for Uninsured Patients Only) $____________________

Balance After Insurance Payments $ ________________________(Co-Insurance, Co-Payment, Deductible)

Note: Medi-Cal Share of Cost amounts are Not eligible for the Charity Care Program.

Additional item for consideration:

If a patient/applicant, incur medical expense out-of-pocket with any medical provider other than our facility within the 12-month period before application date, the out-of-pocket amount can be considered in our review. The patient/applicant would be required to provide documentation (statements) from the medical providers to confirm the amount listed below.

- Total out-of-pocket expense $___________________

Out-of-Pocket expenses are all patient medical bill balances, co-insurance, co-payment or deductible amounts.

The Charity Care program for AHS does not apply to charges billed by any physician who are not billed by AHS.

Patient Attestation

I attest that the financial information I have provided is complete and accurate and I agree that your facility may verify this information. I agree to notify your facility of any changes in my financial circumstances and to provide, upon request, insurance eligibility status.

Patient/Applicant's Signature________________________ **Date** ______________

(If the patient is under 18 years of age, the signature of a parent or guardian is required)

Patient Representative's Signature______________________

Relationship __________________________

(If the patient is unable to sign because of illness or disability)