Financial Assistance Application Instructions

If you need help paying your medical bill, you may be eligible for financial assistance From Orchard Hospital. Any individual whose family income is at or below 400% of the federal poverty level and is either uninsured or has high medical costs may be eligible for the hospital's charity (free) care or discounted care. To determine eligibility for financial assistance, please follow the instructions below in completing the financial assistance application, including submission of supporting documentation, as applicable.

You may be eligible for government programs such as Medi-Cal and other government-funded healthcare assistance programs. Additionally, you are welcome to obtain applications for coverage offered through the California Health Benefit Exchange: www.coveredca.com.

Completion:

Please complete all areas on the attached application form. If any area does not apply to you, please write N/A (not applicable) in the space provided.

Discounted Care:

For purposes of determining eligibility for discounted care, we request that you submit documentation of income limited to (i) pay stubs within three months before or after the patient is first billed or (ii) income tax returns from the year the patient was first billed or 12 months prior to when the patient was first billed. Patients that only apply for discounted care may receive less financial assistance than what may be available to

them under the charity care program. If you only wish to apply for discounted care, Please complete page two and three and date Page Five of the application.

Charity (Free) Care:

For purposes of determining eligibility for charity care, please complete the entire application and write NA for any sections that are not applicable.

Submission:

If you have questions, please call 530-846-9011. Mail or deliver your completed Application in person to: Orchard Hospital P.O. Box 97 Gridley, CA 95948

Orchard Hospital

Patient Information

Patient name		Social Security number	Date of birth	
Home address		City	State	ZIP code
Home phone number	Cellphone number	Email address		

Preferred method of contact
☐ U.S. mail ☐ Email ☐ Home phone ☐ Cell phone

Annual household income:
$_____

Marital status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic partner

Number of individuals in your household (as reported on your taxes):
_____

Employment status
☐ Employed ☐ Self-employed ☐ Retired ☐ Disabled
☐ Unemployed – Last date worked: _____

Employer name	Phone number		
Employer address	City	State	ZIP code

Spouse/Domestic Partner/Parent/Guarantor Information

Relationship to patient
☐ Spouse ☐ Domestic partner ☐ Parent ☐ Guarantor ☐ Other: _____

Name	Social Security number	Date of birth

Employment status
☐ Employed ☐ Self-employed ☐ Retired ☐ Disabled
☐ Unemployed – Last date worked: _____

Employer name	Phone number		
Employer address	City	State	ZIP code

Insurance Coverage

Are you eligible for any health insurance coverage? ☐ **Yes** ☐ **No**
If "Yes," please provide the following:

Policyholder	Insurer	Policy number
Policyholder	Insurer	Policy number

Have you applied for Medi-Cal/Medicaid? ☐ **Yes** ☐ **No**
If "Yes," please describe the results of that application: _____

Have you been screened for Medi-Cal/Medicaid eligibility? ☐ **Yes** ☐ **No**
If "Yes," please describe the results of that screening: _____

Orchard Hospital

Income & Expense Information			
Monthly Income (Current)	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Gross income	$	$	$
Monthly Essential Living Expenses	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Rent or mortgage	$	$	$
Real estate taxes	$	$	$
Home maintenance, cleaning and household supplies			
Utilities and telephone	$	$	$
Clothing and laundry			
Medical and dental			
Alimony/Child support	$	$	$
Transportation and auto (insurance, gas, repairs, lease)	$	$	$
Education	$	$	$
School/Childcare (minor dependents)	$	$	$
Food	$	$	$
Insurance	$	$	$
Other extraordinary expenses	$	$	$
Total monthly expenses	$	$	$

Medical Debt (Current)	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Outstanding medical debt at Cedars-Sinai or Huntington Health	$	$	$
Other medical debt	$	$	$

☐ Yes, I consent to the use of presumptive eligibility for the consideration of Charity Care or Discount Payment.

I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified by the Organization, and I authorize them to contact third-parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provided incorrect information or if the application contains a material error or omission, I will no longer be eligible for financial assistance. If financial assistance was previously granted to me, it may be reversed at that time, and I will be held responsible for the outstanding balance.

_____ _____

Signature of person applying for financial assistance Date

_____ _____

Signature of spouse/domestic partner/guarantor (if applicable) Date