El Camino Health

Financial Assistance Application – Instructions

Attached is an application for El Camino Health's Financial Assistance Program. Please complete, sign and return the application to our office along with the documentation listed below.

Eligibility – You may qualify for Charity Care (100% Discounted Payment) if: (1) you are uninsured or have high medical costs and (2) your family income is at or below 400% of the Federal Poverty Level. We will not consider your savings when reviewing your eligibility. If you qualify, you will not be charged more than insured patients for emergency or medically necessary care.

Documentation – Proof of Income is a requirement for all applicants. Documents that are considered acceptable proof of income are listed below.

- Recent tax returns (meaning tax returns that document a patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed), **or**
- Recent pay stubs (meaning paystubs within a 6-month period before or after the patient was first billed by the hospital, or in the case of preservice, when the Financial Assistance Application is submitted).

Submission – Completed applications and supporting documents can be submitted to our office in any of the following ways:

- **Scan and Email:** charity_care@elcaminohealth.org
- **Fax**: ATTN: Charity Care
  650-966-9334
- **Mail/Drop off:** ATTN: Charity Care / Patient Accounts Department
  2505 Hospital Drive, 2nd Floor
  Mountain View, CA 94040

If you have questions regarding the application process, please contact our Patient Accounts customer service team from 9 a.m. to 4 p.m., Monday through Friday, at **800-665-6540**. You have the right to receive help with this application at no cost, including free interpreter services and translated documents in your language if needed. Please contact us for assistance.

Notice of Rights – Applying for financial assistance will not affect your ability to receive emergency or medically necessary care. You may apply regardless of immigration status.

PATIENT FINANCIAL ASSISTANCE APPLICATION

Date Application Received (to be completed by El Camino Health): _____

Account / Medical Record #: _____

Patient Name: _____

El Camino Health offers charity care (free) to individuals who meet our policy. Please check the box below to indicate if you would prefer not to apply for charity care, but only want to request discounted payments that are not free:

☐ Patients who only apply for discount program eligibility (which is not free and not currently offered by El Camino Health) may receive less financial assistance than what may be available under El Camino Health's charity care program. (Cal. Code Regs., tit. 22, s 96051.8(a)(2).) I acknowledge that El Camino Health does not have a discount program, but do not want to apply for free care.

Applicant (Guarantor) Information:

Relationship to Patient: ☐ Self ☐ Parent/Guardian

Name: _____

Address:_____ City: _____

State, Zip:_____ Telephone Number:_____

Phone Number(s): _____ Cell Phone Number(s): _____

Social Security #:_____ Date of Birth: _____

Employer:_____ Employer Phone:_____

Occupation: _____

Marital Status: _____ Name of Spouse:_____

Number of Dependents _____ Age(s) of Dependents:_____

Annual Family Income: $ _____ (Income documentation is required.)

Please identify basis for eligibility —

You must be either uninsured or have high medical costs.

☐ I am uninsured.

☐ I have high medical costs that exceed 10% of my income.
(Fill out information below.)

A. My current annual family income or family income in the last 12 months (whichever is lower): _____

B. 10% of the family income listed in A: _____

C. Annual out-of-pocket costs incurred by the patient at El Camino Health or Annual out-of-pocket medical expenses paid by the patient or patient's family with supporting documentation (whichever is higher): _____

By signing below, I/We declare that all information provided is true and correct to the best of my/our knowledge. I/We authorize El Camino Health to verify any information listed in this application.

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_____Date _____

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