Instructions for the Charity Care and Discounted Payment Application

You must provide the following information and documents so we can review your application for Charity Care (free care) or Discounted Payment (reduced but not free care) at Watsonville Community Hospital.

Please complete all sections of the application and include the required documents listed below. You may apply at any time, even after you receive your bill, as long as your application includes proof of income, such as recent pay stubs or a recent tax return.

If you are applying for discounted payment only, you are required to provide either recent pay stubs (from within 6 months before or after the first bill) or a recent income tax return (for the year of billing or the 12 months before).

If you are applying for charity care and cannot provide pay stubs or a tax return, you may instead submit a signed affidavit explaining your household income.

If you qualify for discounted payment, you will not be charged more than what Medicare or Medi-Cal would pay for the same services, whichever is greater.

You can return the completed application to the Admitting Department or mail it to the Business Office at the address below:

Attn: Financial Counselors
75 Nielson St.
Watsonville, CA. 95076

Should you need assistance or have any questions regarding the Charity Application, please call 831-761-5689 or 831-761-5690.

List of Documents Required to Complete the Application

Required Documentation for Income Verification

To apply for **Charity Care** (free care) or **Discounted Payment** (reduced but not free care), please provide **one** of the following:

- Recent pay stubs (covering the 6 months before or after the date of your first billing statement), or
- Most recent income tax return (for the year of billing or the 12 months prior)

If you are applying for Charity Care and are unable to provide pay stubs or a tax return, you may instead submit:

- Signed affidavit explaining your household income

Note: If you are applying for Discounted Payment only, you are required to provide either pay stubs or a tax return. An affidavit is not accepted for Discounted Payment eligibility.

Additional Documents (if applicable):

- Copy of photo ID and Social Security Card
- Homeless Affidavit (if applicable)

Note on Income: Family income includes wages, Social Security, unemployment benefits, retirement income, child or spousal support, and other earnings. You do not need to report savings, property, or retirement accounts unless they produce regular income.

Charity Care and Discounted Payment Application

To be completed by financially responsible party. Please complete this application in its entirety.

Date: _____

Patient Information

Patient's Name: _____

Patient's Employer (optional): _____

Spouse's Name (if applicable): _____

Spouse's Employer (optional): _____

Patient's Address: _____

City: _____ State: _____ ZIP: _____

Patient's Phone #: _____

Patient's Date of Birth: _____

Spouse's Date of Birth (if applicable): _____

Patient's Social Security Number (optional): _____

Spouse's Social Security Number (optional): _____

Guarantor Information

(Only complete if someone other than the patient is financially responsible for the bill.)

Guarantor's Name: _____

Relationship to Patient: _____

Guarantor's Address: _____

City: _____ State: _____ ZIP: _____

Guarantor's Employer (optional): _____

Guarantor's Social Security Number (optional): _____

Household Income Information

(Report total income for the past 12 months from all household members who contribute to expenses, including patient, spouse, and/or guarantor.)

Income Source	Amount (12-month total)
Wages	$ _____
Social Security	$ _____
Unemployment	$ _____
Alimony or Child Support	$ _____
Military Allotment	$ _____
Disability	$ _____
Rental Income	$ _____
Other (describe): _____	$ _____

Income Documentation – Check ONE box below (required)

To determine your eligibility for Charity Care or Discounted Payment, please provide one of the following:

□ Recent pay stubs (covering the 6 months before or after the first billing statement)

□ Most recent income tax return (for the year of billing or the 12 months prior)

□ Signed affidavit explaining your household income (only if you are applying for Charity Care and cannot provide pay stubs or a tax return)

Extended Payment Plan Consideration

If you still owe a balance and want to set up a monthly payment plan, Watsonville Community Hospital will work with you to find a monthly amount that is fair. We look at your family income and basic living expenses to help decide what you can reasonably afford to pay each month.

You may choose to share more details about your basic monthly living expenses below. You do not need to give us any other documents beyond what you already provided for your financial assistance application.

Optional: Monthly Essential Living Expenses

House / Rent Payment: $ _____ Food: $ _____ Insurance: $ _____

Gas & Electricity: $ _____ Water: $ _____ Trash: $ _____

Child Support: $ _____ Auto Expenses: $ _____

Statement

I certify the information I have provided in this application is true and accurate to the best of my knowledge. I understand that WCH will use this information to determine whether I qualify for financial assistance under its Charity Care and Discounted Payment policy.

I understand that WCH may verify the information provided and may use publicly available data to help assess eligibility. I also understand that eligibility for financial assistance is based solely on income, consistent with the Federal Poverty Guidelines.

Applying for other programs such as Medi-Cal or Medicare is encouraged, but not required in order to qualify for Charity Care or Discounted Payment. WCH will not deny financial assistance based solely on a patient's failure to apply for other coverage or assistance programs.

I understand that the information I submit for financial assistance will not be used in collection efforts. .

Signature of the applicant: _____ Date: _____

Witness: _____ Date: _____

Homeless Affidavit

I, _____, certify that I am currently homeless and do not have a permanent address. I do not have regular income from employment. Any support I receive may come from public programs or donations from others.

I certify that the information provided in this affidavit is true and correct to the best of my knowledge. I understand that knowingly providing false information may result in denial of financial assistance.

Watsonville Community Hospital may use publicly available data to verify the information provided. A credit report is not required and will not affect eligibility for Charity Care or Discounted Payment.

Eligibility for financial assistance is based solely on family income, consistent with the Federal Poverty Guidelines.

I authorize Watsonville Community Hospital to pursue any applicable insurance benefits or third-party payments for services provided, including any benefits I have previously assigned or may assign, in connection with this care.

_____ _____

Patient/Guarantor Signature Date