Financial Assistance Application

Thank you for choosing Henry Mayo Newhall Hospital (HMNH) for your health care needs, where we strive to improve the health of our community through compassion and excellence in health care services. You may be eligible for financial assistance to assist you in paying health care services you will or have received at HMNH. This financial assistance applies to your hospital bill only, and does NOT apply to bills you may receive from your physicians or surgeons, although if this application is approved, some providers may extend a full or partial courtesy discount based upon the hospital acceptance determination letter.

Henry Mayo Newhall Hospital's Financial Assistance Program provides financial assistance to patients with medically necessary health care needs who are low-income based on their individual family financial situation.

Based on current Federal Poverty guidelines, you may qualify for free or discounted care. If your family income is at or below 200% of the Federal Poverty Level, you may be eligible to receive hospital services at no cost to you, otherwise known as full charity care financial assistance. If your family income is between 201% to 400% of the Federal Poverty Level, you may be eligible to receive discounted care. Under discounted care, your payment is reduced but not free.

To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please complete this form and provide the most recent supporting documentation: An income tax filing (which document the 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** 2 pay check stubs within a 6-month period before or after the patient is billed by the Hospital, or in the case of a pre-service application, when the financial assistance application is submitted.

Please submit the completed forms and supporting documentation to Patient Access Services in person located in the main admitting area of the hospital, or by mail to:

Henry Mayo Newhall Hospital
23845 Mc Bean Pkwy Valencia, CA 91355.
Attn: Patient Financial Services

Account Number_____ Date of Application_____

Patient Name _____ Guarantor Name _____

Spouse Name _____

Address_____ Phone number_____

_____ Social Security #_____

Date of Birth ___ /___ /___ Sex____ M=Male F=Female

Number of family members: _____

- For persons 18 years of age and older, spouse, domestic partner, dependent children under 21 years of age, or any age if disabled, whether living at home or not, and
- For persons under 18 years of age, or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, parents or care taker relatives' other dependent children under 21 years or any age if disabled.

List Family Members:

Name	Relationship	Age

Wages/Income:

	Monthly	Annually
Total Household Wages*	_____	_____

* Wages should include income from employment, self-employment, public assistance, social security, unemployment benefits, retirement/pension, alimony, child support, etc.

Please check the type of financial assistance you are interested in applying for (most patients will check both boxes):

☐ Full Charity Care

☐ Discount Payment: Patients applying only for the Discount Payment Program may receive less financial assistance than may be available under Charity Care

My signature attests that the information I have provided on this form and the additional supporting documentation is accurate and true to the best of my knowledge.

_____	_____	
Print Name	**Signature**	**Date**

Help Paying Your Bill

Various government assistance programs provide health coverage for individuals with financial need, including Medi-Cal and the Covered California exchange. For patients that are California residents, you may be eligible for health coverage through Covered California or Medi-Cal Presumptive Eligibility. For information, visit the Covered California website at: www.coveredca.com or call our Patient Financial Services Office at 661.200.1117.

There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information. HMNH's Patient Financial Services can also provide information about

If you need any further information or assistance in completing the application, please make an appointment to come to the hospital at Patient Access Services, Main Admitting, or call 661-200-1050, Monday through Friday, 8:00 AM through 5:00 PM and a representative will assist you. For more information about the Financial Assistance Program, you may visit our website at: https://www.henrymayo.com/patients-visitors/billing-insurance-and-financial-assistance/financial-policies/

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.