CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE
FINANCE DEPARTMENT

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TITLE: Patient Financial Assistance – Discounted Care and Charity Care

Formulated: 6/87
Reviewed:
Revised: 8/90, 8/91, 4/97, 9/97, 7/98, 5/01, 2/03, 6/05, 1/07, 2/11, 6/11, 5/13, 6/13, 9/13, 12/14, 3/16, 5/18, 11/18, 2/19, 8/19, 11/19, 2/20, 11/21, 1/22, 5/26

POLICY:

Casa Colina, Inc. and its affiliated corporations (referred to collectively as Casa Colina) strive to provide quality services in a caring environment and to make a positive measurable difference in the health of individuals we serve. Helping to meet the needs of the low-income, uninsured and underinsured patients is an important element of our commitment to the community. Casa Colina's financial assistance policy provides the means for the organization to demonstrate its commitment to achieving its mission and values.

The criteria Casa Colina will follow in qualifying patients for programs for financial assistance purposes are provided in this policy. The financial assistance policy has been developed in written form to effectively communicate how our commitment will be consistently administered to all parties. Patients who receive necessary services at Casa Colina and who do not have third party insurance coverage for their entire bill and who have difficulty paying their bills because of financial hardship are covered under the terms of the financial assistance policy.

Casa Colina recognizes the importance to create a charitable service policy that considers the needs of its community while balancing its long-term fiduciary responsibility. In the long run, sustainability of the organization remains essential to maintaining programs and services for the community. Casa Colina shall make available such amounts (budgeted annually) for financial assistance to patients.

This policy separates and differentiates between Discounted Care and Charity Care.

DEFINITION:

DISCOUNTED CARE is defined as services provided to patients who are either uninsured with higher income levels or are underinsured but whose income is at or below four hundred percent (400%) of the federal poverty level standard.

CHARITY CARE is defined as services customarily provided by Casa Colina, which are provided to patients who do not have available resources to pay and ~~meet~~ are at or below

200% of the federal poverty level. The services are provided either free or at nominal prices.

Charity Care or Discounted Care will not include administrative adjustments or contractual adjustments. Charity Care and Discounted Care shall be based on Federal Poverty Level (FPL), as well as other appropriate guidelines. The FPL guidelines are established and published in the Federal Register each calendar year (usually February) and adjust for family size.

Discounted Care

A. To qualify for a discounted payment a patient must meet the following criteria:

1. A patient's family income is at or below 400% of the Federal Poverty Level ("FPL").

2. A patient who is uninsured is a patient who does not have third-party coverage from a health insurer, healthcare service plan, Medicare, Medi-Cal, Regional Center and whose injury is not eligible for compensation under worker's compensation, automobile insurance, or other insurance as determined and documented by Casa Colina's Financial Services Department.

3. A patient who is insured but has "high medical costs" and who is at or below 400% of the Federal Poverty Level (FPL). A patient with high medical costs is defined as: a person whose family income does not exceed 400 percent of the federal poverty level and that individual does not receive a discounted rate from the hospital as a result of his or her third-party coverage. For these purposes, "high medical costs" means any of the following:

   a. Annual out-of-pocket medical expenses incurred by the individual at the hospital that exceed 10 percent of the patient's current family income or family income in the prior 12 months, whichever is less.
   b. Annual out-of-pocket medical expenses that exceeded 10 percent of the patient's current family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

4. A patient must meet the income ~~and asset~~ tests as determined by California statute. Such tests are based on the "patient's family income" in that in defining a patient with high medical costs, a comparison of the patient's out-of-pocket expenses at Casa Colina to the "patient's family income," or a comparison of the patient's family income to medical expenses "paid by the patient or the patient's family."

   a. For persons 18 years of age and older, the patient's spouse, domestic partner, and dependent children per IRS guidelines, whether living at home or not.
   b. For persons under 18 years old, a parent, caretaker relatives, and other dependent children of the parent or caretaker relative.

5. A patient who receives a discount as a result of his/her third-party coverage may not be eligible for additional discounting of their remaining liability. If the patient's liability is based on a contractually discounted rate between Casa Colina and the insurer, the remaining patient liability may not be eligible for additional discounting.

6. Patient eligibility is determined based solely on the family's income; assets such as primary residence are not considered in the eligibility criteria.

7. Any patient who does not reasonably comply with Casa Colina's application process may be excluded from eligibility.

8. The patient's eligibility may be determined anytime Casa Colina is in receipt of documentation of income and expenses.

~~8.~~9. Casa Colina will limit charges to a patient eligible for financial assistance to the amount the hospital would expect, in good faith, to receive for providing services from Medicare or Medi-Cal, whichever is greater, if this amount is lower than the discounted amounts included within this policy.

B. Casa Colina is required to notify uninsured, underinsured, and low-income patients of the availability of discounted and charity care programs. The process for notification shall consist of two types: (1) Written (Exhibit G) and 2) Public notice (Exhibit F)

1. Written Notice

The written notice shall include the following:

a. The availability of discounted/charity care that is based on a family's current income or family's income in the prior 12 months, whichever is less, in conjunction with the federal poverty guidelines as well as the availability of state and federal applications for medical coverage and eligibility information in both English and Spanish.

b. If it is determined that the patient's primary language is other than English or Spanish, and that language comprises greater than 5% of the facility's population, Casa Colina will provide the necessary information in the patients primary language.

c. The written notice will be published online at: www.casacolina.org/financialassistance. The Financial Assistance Policy Plain Language Summary (Exhibit D) will also be available at this web address.

2. Public Notice

The notices shall be posted in areas, which are clearly and conspicuously visible to the public. Such areas (check-in, registration, admissions office, billing office and other outpatient areas, including observation units) shall include, but are not limited to: Inpatient Services, Children's Services, Specialty Clinics, Imaging Center, Adult Day Healthcare, and other outpatient settings such as Laboratory, Wound Care, and Radiology.

C. The application process for Discounted Care is as follows:

1. Admissions, Registration, and Patient Financial Services personnel will accept requests for consideration for discounted care. In addition, program manager/director and or other appropriate Casa Colina personnel, such as case managers and patient accounting representatives may accept requests for discounted care.

2. The patient, family, or financially responsible party shall complete the Application for Financial Assistance (see Exhibit A & B) and return it to the Patient Financial Services Department.

~~3.~~ Financial assistance will be granted based on a completed application. The discounted care eligibility of the patient is identified below. Eligibility for discounted care will be determined by a thorough financial screening process utilizing the data included in the financial assistance form. Required documentation includes recent pay stubs from within the last six months and federal income tax returns for the patient or patient's family.~~Data collected includes:~~

~~4.~~

~~5. Completed and signed financial assistance application;~~

~~6. Award letters for Social Security, SSI, Disability, Unemployment, General Relief, Alimony, etc.;~~

~~7. Family income from all sources:~~

~~8. Most recent tax returns~~

~~9. Two most recent pay stubs;~~

~~10. Employment status, both current and future; or, if self-employed, current year-to-date profit and loss statement to determine current income;~~

~~11. Family size;~~

~~12. Last two months' bank, brokerage, and investment statements;~~

~~13. Copies of prior year's 1099 for interest income, dividends, capital gains, etc.; and~~

~~14. Other appropriate financial data if tax returns or pay stubs are not available. Certain patient's assets, such as retirement plans, homes, and automobiles owned by the patient, are excluded.~~

~~15. Rent verification~~

~~16.~~3. ~~Property/mortgage verification~~

4. Failure by the patient/client to provide adequate and complete information to substantiate the necessity for discount/charity care may result in the application being denied.

5. The initiator of the request will review the application for completeness and they will complete the Financial Assistance Request Form (Exhibit C). The completed request will then be returned to the Director of Patient Financial Services.

6. Casa Colina may accept deposits from a patient prior to the determination of discounted care. Should a deposit be made, Casa Colina shall refund such appropriate funds in a timely manner, including appropriate interest thereupon.

7. The Director of Patient Financial Services will complete the financial worksheet and compare the data to established poverty level guidelines (see Exhibit E).

8. The Director of Patient Financial Services will recommend approval or rejection of the submitted application and forward qualifying requests to the Chief Financial Officer for approval or rejection.

9. The Chief Financial Officer will forward the approved application to the Chief Planning and Development Officer and the Chief Executive Officer for final approval or rejection.

10. If all levels of approval are given, the Director of Patient Financial Services will inform the patient or designated representative of such approval. The original application is maintained in Patient Financial Services Department for the period of 10 years or as required by current regulations. In the event that the application for financial assistance is denied, the requesting party will be notified in writing. Approvals and denials will be supported by reasonable documentation supporting such decisions as outlined in the federal poverty guidelines (FPL). All decisions will be communicated in writing to the requestor no later than 14 business days from final approval or denial date.

11. The patient may contact the Director of Patient Financial Services or designee in the event of a dispute of our determination.

12. A patient may appeal a denial. The Director of Patient Financial Services shall review all the financial data along with the application on file. The

patient may submit additional information, including, but not limited to updated financial data and/or other relevant information to substantiate the request for financial assistance.

13. Patients are eligible for a re-evaluation under the financial screening procedure:

    a. At the time of each inpatient/outpatient admission.
    b. When any relevant data previously considered has changed, such as income, family size, special or unusual expenses, and so on.
    c. After one year elapses from the completion of their last financial screening.

14. The Finance Department will maintain a log of all approved Discounted Care and Charity Care adjustments.

D. The billing and collection process in regard to discounted care is identified as follows:

1. For patients who have not provided adequate proof of insurance, the Patient Financial Services department shall provide information in summary form along with appropriate contact information regarding the Patient Financial Assistance Policy. The information Casa Colina shall provide is as follows:

    a. A statement of charges for services rendered by Casa Colina.
    b. A request that the patient inform the patient financial services department if the patient has health insurance coverage, Medicare, Healthy Families, Medi-Cal, or other coverage.
    c. Medicare patients seeking financial assistance for a copayment, co-insurance, or deductible assigned by Medicare are candidates for Medicare Bad Debt after 180 days from the first bill date and after reasonable collection efforts were made by Patient Accounting and a Debt Collection Agency to collect the debt. These balances are not considered Charity Care.
    d. A statement indicating that a patient may obtain an application for Medi- Cal, California Health Benefit Exchange (Covered California), and CCS.
    e. Information about the “Financial Assistance Application” including:

        i. A statement that indicates that if the patient lacks, or has inadequate, insurance and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care.

ii. Reasonable efforts to obtain a patient's third party health coverage information, including coverage through the California Health Benefits Exchange will be made. The hospital will notify the patient that they may be eligible for health coverage through the California Benefit Exchange, or other state- or county-funded health coverage.

2. Should a patient qualify for partially discounted care, the remaining balance due will be collected using the standards and practices of Casa Colina for billing and collections. External collection agencies utilized by Casa Colina shall also adhere to Casa Colina standards and practices. All debt collection practices will include all appropriate fair debt language. The standards and practices are as follows:

   a. Prior to the debt being advanced to a collection agency, Patient Financial Services shall make reasonable efforts to inform the patient/client of the status of their financial obligation. That includes but is not limited to:

      i. An initial itemization of charges incurred.
      ii. Three monthly billing statements. The third and final notice will be sent no less than 120 days from determining the balance is patient responsibility.
      iii. A telephone call will be placed after 30 days from the bill date to collect payment in full or negotiate a payment arrangement if no response to previous statement(s) has been received.

   b. Any debt assigned to a collection agency must have met the above criteria and the assignment date must be greater than 180 days from initial billing. The exception to the above would be any account that is deemed to be uncollectible due to inaccurate address (returned mail with no forwarding address, phone, or bankruptcy).
   c. Neither Casa Colina nor a collection agency may use wage garnishments or file liens on assets except if court ordered.
   d. A patient may request an extended payment arrangement to satisfy the remaining debt once the discount has been applied. Such extension should be based on the circumstances of each patient with a standard installment of up to 6 months and must be approved by the Director of Patient Financial Services. If Casa Colina and the patient cannot agree on repayment plan terms, default monthly payments will consist of an amount not more than 10 percent of a patient’s family income for a month,

excluding deductions for essential living expenses as defined in California Health and Safety Code Section 127400(i).

e. No interest may be charged during the payment period. Should the patient fail to make payment for ninety days (90) days or fail to renegotiate the payment plan, Casa Colina will take immediate action and assign unpaid debt for immediate collections.

f. Patient debt is advanced for collection under the authority of Casa Colina's Chief Financial Officer (CFO), who is responsible for overseeing debt collection activities.

~~e.~~g. Casa Colina shall not use any income documentation – including but not limited to paystubs, income tax returns, or other financial records – obtained during the financial assistance or charity care eligibility determination process for any debt collection activities. This restriction applies to both internal collection efforts and any third-party collection agencies acting on behalf of Casa Colina. Casa Colina affirms that such documentation is collected solely for the purpose of evaluating eligibility for financial assistance and shall not be repurposed for assessing collectability, initiating collection actions, or determining payment plans.

Charity Care

A. For a patient to qualify for charity care they must meet the following criteria:

1. A patient is at or below 400% of the Federal Poverty Level ("FPL").

2. If a patient's family income is 200% or less of the FPL, then entire amount of the bill will be forgiven.

3. If a patient's family income is between 201% and 400% of the FPL, then a portion of bill is forgiven based on a sliding scale as follows:

   a. 201% to 250% = 75 % forgiven
   b. 251% to 300% = 50% forgiven
   c. 301% to 400% = 25% forgiven

4. If a patient's family income is more than 400% of the FPL, the patient will not automatically qualify for charity care adjustment based on the income level. However, financial assistance may be considered when the specific circumstances of care were created by a catastrophic medical condition or event.

5. Casa Colina shall request and verify the same personal financial information as required for Discounted Care above. ~~In assessing the~~

~~patient/clients monetary assets, the first $10,000 of a patient's monetary assets and 50% of assets above $10,000 will not be considered in determining eligibility.~~

OTHER ELIGIBLE CIRCUMSTANCES:

Casa Colina deems those patients that are eligible for any or all government sponsored low-income assistance programs to be indigent. Therefore, such patients are automatically eligible for Charity Care under the Casa Colina Policy and account balances will be classified as Charity Care if the government program does not make payment for all services provided, or days during a hospital stay.

For example, patients who qualify for Medi-Cal, CCS, CHDP, MSI, CMSP, or other similar low-income government programs are eligible for financial assistance.

Any or all non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any other failure to pay for covered or non-covered services provided to Medi-Cal and/or other government low-income qualified patients are covered.

Patients with restricted coverage and/or other forms of limitation shall have non-covered amounts classified as Charity Care when payment is not made by the low-income government program.

The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as Charity Care if:

1. The patient is a beneficiary under Medi-Cal or another program serving the healthcare needs of low-income patients; or
2. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

Any patient who experiences a catastrophic medical event may be deemed eligible for financial assistance. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $100,000 may be considered for eligibility as a catastrophic medical event.
Any account returned to the hospital from a collection agency, where it has been determined the patient or guarantor does not have the resources to pay their bill, may

be deemed eligible for Charity Care. Documentation of the patient or guarantor's inability to pay for services will be maintained in the Charity Care documentation file.

CRITERIA FOR RE-ASSIGNMENT FROM BAD DEBT TO CHARITY CARE

All outside collection agencies contracted with Casa Colina to perform account follow-up and/or bad debt collection will utilize the following criteria to identify a status change from bad debt to Charity Care:

1. Patient accounts must have no applicable insurance coverage including governmental or other third party payers);
2. The patient or guarantor must have an Experian credit score rating of less than or equal to 500. If the collection agency is using a credit scoring tool other than Experian, the patient and or guarantor must fall into 20th percentile of credit scores for the method used;
3. The patient or guarantor has not made a payment within one hundred eighty (180) days of assignment to the collection agency;
4. The collection agency has determined that the patient/guarantor is unable to pay;
5. The patient does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score; and
6. Medicare patients assigned to an outside collection agency after 180 days from the first statement and unable to pay or has not paid for a copayment, co-insurance, or deductible assigned by Medicare are candidates for Medicare Bad Debt. The outside agency has to exhaust collection efforts outlined by the hospital provider and return the account as Medicare Bad Debt to the Hospital after 45 days of reasonable collection efforts. Accounts are returned as Medicare Bad Debt. These balances are not considered Charity Care.

ATTACHMENT(S):

Exhibit A – Financial Assistance Application *(English)* (attached within P&P) *(Reviewed 11/18/21, 1/2022, 5/2026)*

Exhibit B – Financial Assistance Application *(Spanish)* (attached within P&P) *(Reviewed 11/18/21, 1/2022, 5/2026)*

Exhibit C – Financial Assistance Request Form (attached within P&P) *(Reviewed 11/18/21, 1/2022, 5/2026)*

Exhibit D – Financial Assistance Policy Plain Language Summary (attached within P&P) *(Formulated 11/18/21; Revised 1/2022; Reviewed 5/2026)*

Exhibit E – Financial Worksheet and 2026 Federal Poverty Guidelines (attached within P&P) *(Revised 1/20/26)*

Exhibit F – Public Notice of the Availability of Discount/Charity Care Programs *(English & Spanish)* (attached within P&P) *(Reviewed 11/18/21, 1/2022, 5/2026)*

Exhibit G – Written Notice of the Availability of Discount/Charity Care Programs *(English & Spanish)* (attached within P&P) *(Reviewed 11/18/21, 1/2022, 5/2026)*

Exhibit H – Covered California Fact Sheet *(English & Spanish)* (attached within P&P) *(Reviewed 11/18/21, 1/2022; Revised 5/2026)*

Exhibit I – County of Los Angeles DHCS List of Local Programs *(English & Spanish)* (attached within P&P) *(Reviewed 11/18/21, 1/2022)*

EXHIBIT A

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CASA COLINA
Hospital and Centers for Healthcare

Requested By: _____

Financial Assistance Application

Date: _____

Patient /Guarantor Name:

_____

Address:

_____

Please complete and provide all requested information to the best of your abilities in order for Casa Colina Hospital and Centers for Healthcare to accurately determine if you qualify for our Financial Assistance Program, which is based on Federal Poverty Guidelines. We cannot guarantee that you will qualify for financial assistance, even if you apply. Patients that only apply for discounted care may receive less financial assistance than what would be available under the charity care program.

You are only required to submit recent pay stubs within the last six months and your most recent income tax return (such as IRS Form 1040) for the patient or patient's family. You may submit other documents regarding proof of income listed below if you wish, but they are not required. For example, if you have no proof of income or no income, you may attach an additional page with an explanation. Here are documents you may wish to provide:

- ✓ Pay stubs (most recent available)
- ✓ Most recent tax returns
- ✓ Completed and signed Financial Assistance Application
- ✓ Award letters for Social Security, SSI, Disability, Unemployment, General Relief, Alimony, etc.
- ~~✓ Most recent tax returns~~
- ~~✓ Pay stubs (most recent available)~~
- ✓ Employment status, both current and future; or, if self-employed, current year-to-date profit and loss statement to determine current income
- ✓ Family size
- ✓ Last two months' bank, brokerage and investment statements
- ✓ Copies of prior year's 1099 for interest income, dividends, capital gains, etc.
- ✓ Other appropriate financial data if tax returns or pay stubs are not available. Certain assets—such as retirement plans, homes, and automobiles owned by the patient—are excluded.
- ✓ Rent verification
- ✓ Property/mortgage verification
- ✓

Please note that any incomplete application will be denied and sent back to you for completion and/or supporting documentation. If you have any questions, please contact our **Patient Financial Services Department** at **909/596-7733, ext. 5558**. Faxed requests can be faxed to **909/450-0141.**

Enclosure: [ ] **Application: [ ]**

For Casa Colina Internal Purposes Use Only

Please complete the below information prior to providing the application to the applicant. For questions or clarification, please contact the **Director of Patient Financial Services** at ext. 5558.

Department:	
-Team	
Number:	
Date Application was given to the	
Applicant:	
Internal Requestor:	

Financial Assistance Application

Patient's Name: _____ Phone: ( )_____

Address: _____ Date of Birth: _____

_____ Sex: ☐ Female ☐ Male

Social Security No: _____

SECTION 1: FAMILY INFORMATION

List all persons living in the household who are related by birth, marriage, and/or adoption. Include related college students who do not reside with family but are supported by the family.

Name	Date of	Sex	Relationship	Social Security

SECTION 2: GROSS MONTHLY INCOME

List all employers for each member of household and attach proof of gross income (before taxes or deductions).

Required proof of income: Recent pay stubs from within the last 6 months and federal income tax return.

Other: Profit/loss statement from accountant (for self-employed persons).

Name	Employer Name, Address, & Phone	Monthly Income

List all other income including social security, railroad retirement, unemployment compensation, worker's compensation, welfare/AFDC, supplemental security income, alimony, child support, military allotment, support from an absent family member or someone not living in the household, private or government pensions, insurance or annuity payments, income from dividends, interest, rents, royalties, and/or estates/trusts.

Source of Income	Monthly Income

Financial Assistance Application

Patient's Name: _____ Phone: (_____) _____

Address: _____ Date of Birth: _____

_____ Sex: ☐ Female ☐ Male

Social Security No: _____

SECTION 1: FAMILY INFORMATION

List all persons living in the household who are related by birth, marriage, and/or adoption. Include related college students who do not reside with family but are supported by the family.

Name	Date of	Sex	Relationship	Social Security

SECTION 2: GROSS MONTHLY INCOME

List all employers for each member of household and attach proof of gross income (before taxes or deductions).

Examples of Required proof of income: Recent pay stubs from within the last 6 months and federal income tax return or check stub(s).

Other: , pProfit/loss statement from accountant (for self-employed persons).

Name	Employer Name, Address, & Phone	Monthly Income

List all other income including social security, railroad retirement, unemployment compensation, worker's compensation, welfare/AFDC, supplemental security income, alimony, child support, military allotment, support from an absent family member or someone not living in the household, private or government pensions, insurance or annuity payments, income from dividends, interest, rents, royalties, and/or estates/trusts. Please attach proof of income.

Source of Income	Monthly Income

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SECTION 3: MONTHLY INCOME

Briefly describe your employment status including date of hire and/or last date of employment/retirement. If you are receiving income from other sources, describe the type of support, the date support began, and the date the support is expected to end, if applicable. Also, describe any other pertinent details about your income.

Identify ALL sources of monthly income for your household. Enter the person receiving the income and the amount received each month for each income category that is applicable.

OCCUPATION:	Documentation (Optional unless noted)	Patient or Applicant	Spouse/Other Family
Wages	2 current pay stubs (Required)		
Hourly rate			
Average monthly hours worked			
Self-employment gross receipts	YTD P&L Schedule (1)		
Partnership income	YTD P&L Schedule (1)		
Social Security	Award		
Supplemental Security Income (SSI)	Award		
Unemployment	Award		
Disability	Award		
Workers compensation	Award		
General relief	Award		
Temporary Assistance for Needy Families	Award		
Food stamps/Electronic Benefit Transfer	Award		
Alimony	Award		
Child support	Award		
Student loans	Award		
Pension/Annuities	Last year's 1099		
Interest income	Last year's 1099		
Dividends	Last year's 1099		
Capital gains	Last year's 1099		
Gross rental income			
Other:			
TOTAL MONTHLY INCOME			

(1) YTD P&L Statement means the current year-to-date profit & loss statement for the business/partnership. If your family does not have income, in the space below, please describe how you have been able to meet your needs for food and shelter. If another person has been providing support, in addition to the below, please ask the person to send Casa Colina Hospital and Centers for Healthcare a letter describing the type of support, frequency, and duration of the support.

~~SECTION 3: MONTHLY INCOME~~

~~Briefly describe your employment status including date of hire and/or last date of employment/retirement. If you are receiving income from other sources, describe the type of support, the date support began, and the date the support is expected to end, if applicable. Also, describe any other pertinent details about your income.~~

~~Identify ALL sources of monthly income for your household. Enter the person receiving the income and the amount received each month for each income category that is applicable. In addition to completing this application, for each type of income that you identify below, submit the required documentation listed AND your most recently filed tax return including ALL supporting schedules, two months of bank statements, savings account statements, and brokerage/investment statements.~~

~~OCCUPATION~~:	~~Required Documentation (Optional unless~~	~~Patient or Applicant~~	~~Spouse/Other Family~~
~~Wages~~	~~2 current pay stubs (Required)~~		
~~Hourly rate~~			
~~Average monthly hours worked~~			
~~Self-employment gross receipts~~	~~YTD P&L Schedule (1)~~		
~~Partnership income~~	~~YTD P&L Schedule (1)~~		
~~Social Security~~	~~Award~~		
~~Supplemental Security Income (SSI)~~	~~Award~~		
~~Unemployment~~	~~Award~~		
~~Disability~~	~~Award~~		
~~Workers compensation~~	~~Award~~		
~~General relief~~	~~Award~~		
~~Temporary Assistance for Needy Families~~	~~Award~~		
~~Food stamps/Electronic Benefit Transfer~~	~~Award~~		
~~Alimony~~	~~Award~~		
~~Child support~~	~~Award~~		
~~Student loans~~	~~Award~~		
~~Pension/Annuities~~	~~Last year's 1099~~		
~~Interest income~~	~~Last year's 1099~~		
~~Dividends~~	~~Last year's 1099~~		
~~Capital gains~~	~~Last year's 1099~~		
~~Gross rental income~~			
~~Other:~~			
~~TOTAL MONTHLY INCOME~~			

~~(1) YTD P&L Statement means the current year-to-date profit & loss statement for the business/partnership. If~~

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~~your family does not have income, in the space below, please describe how you have been able to meet your needs for food and shelter. If another person has been providing support, in addition to the below, please ask the person to send Casa Colina Hospital and Centers for Healthcare a letter describing the type of support, frequency, and duration of the support.~~

SECTION 4: MONTHLY EXPENSES	Patient or Applicant	Spouse/Other Family
Mortgage of owner-occupied residence		
Mortgage of rental property		
Rent		
Property taxes		
Car payment		
Childcare		
Cell phone		
Food & household supplies		
Car insurance & gas		
Clothing		
Medical & dental expenses		
Insurance		
Credit card payments		
Tuition		
Child support		
Spousal support		
Installment payments		
Laundry & cleaning expenses		
Other:		
TOTAL MONTHLY EXPENSES		

If the reported monthly expenses exceed reported income, explain how you are able to meet these financial obligations.

Please state if the patient has applied for Medi-Cal or any other government programs. If yes, please provide information below:

Program Name: _____

ID/Policy #: _____

Date of Program: _____

Other:

Program Name:

ID/Policy #:

Date of Program:

Other:

SECTION 5: OTHER

Are you employed? ☐ Yes ☐ No Will you be employed in the future? ☐ Yes ☐ No

Have you filed bankruptcy? ☐ Yes ☐ No If so, when?

Also, please include any further information you feel might be helpful or make any statement you believe would assist us in reviewing your application.

PURPOSE: The purpose of this information is to determine your ability to pay for services at Casa Colina Hospital and Centers for Healthcare or your possible eligibility for a medical assistance program. This information is NOT an application for Medi-Cal, County Medically Indigent Services Program, California Children Services, Healthy Families, or any other county assistance program.

YOU MUST CONTACT THE DEPARTMENT OF SOCIAL SERVICES IN YOUR COUNTY OF RESIDENCE TO APPLY FOR ASSISTANCE PROGRAMS.

I certify the above information to be accurate and complete, and that this application is made for Casa Colina and Centers for Healthcare to determine my eligibility for discounted or charity care. I understand that Casa Colina Hospital and Centers for Healthcare reserves the right to verify all information supplied, including permission to contact employers and to check my/our credit history. I agree to notify the Patient Accounting Department of any change in my financial information within 10 days of the change.

I UNDERSTAND THAT I MAY BE STILL RESPONSIBLE FOR THE FULL AMOUNT OF MY CHARGES AT CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE.

Signature of Patient/Responsible Party:

Printed Name:

Printed Name:

Signature of Casa Colina Hospital and Centers for Healthcare

~~Healthcare~~

Date: _____

Date: _____

EXHIBIT B

CASA COLINA
Hospital and Centers for Healthcare

Solicitado por: _____

Solicitud de ayuda económica

Fecha: _____

Nombre del paciente/garante: _____

Dirección: _____

Llene y brinde toda la información solicitada de la mejor manera posible para que Casa Colina Hospital and Centers for Healthcare pueda determinar con precisión si usted es apto para recibir nuestro Programa de ayuda económica, el cual se basa en las Pautas Federales de Pobreza. No podemos garantizar que usted califique para recibir asistencia financiera, incluso si la solicita. Los pacientes que solo solicitan atención con descuento pueden recibir menos asistencia financiera de la que estaría disponible bajo el programa de atención de caridad.

Solo se le requiere presentar recibos de pago recientes de los últimos seis meses y su declaración de impuestos sobre la ingresos más reciente (como el Formulario 1040 del IRS) del paciente o de la familia del paciente. Si lo desea, puede presentar otros documentos de prueba de ingresos enumerados a continuación, pero no son obligatorios. Por ejemplo, si no tiene prueba de ingresos o no tiene ingresos, puede adjuntar una página adicional con una explicación. Aquí están los documentos que es posible que desee proporcionar:

- ✓ Boletas de pago (las más recientes que tenga)
- ✓ Declaraciones de impuestos más recientes
- ✓ Solicitud de ayuda económica llenada y firmada
- ✓ Cartas de otorgamiento para el seguro social, SSI, discapacidad, desempleo, ayuda general, pensión alimenticia, etc.
- ✓ Situación laboral, actual y futura; o, si es trabajador autónomo, declaración de ganancias y pérdidas actuales del año hasta la fecha para determinar el ingreso actual
- ✓ Tamaño de la familia
- ✓ Estados de cuenta bancaria, corretaje e inversiones de los dos últimos meses
- ✓ Copias del formulario 1099 del año calendario pasado con información sobre ingresos por intereses, dividendos, plusvalía, etc.
- ✓ Otros datos financieros pertinentes si no se cuenta con declaraciones de impuestos o boletas de pago. Se excluyen ciertos bienes del paciente, tales como planes de jubilación, casas y automóviles de propiedad del paciente.
- ✓ Verificación del alquiler (renta)
- ✓ Verificación de bienes inmuebles/hipoteca

Tenga en cuenta que cualquier solicitud incompleta será denegada y enviada de vuelta para ser llenada y/o para que se añadan documentos pertinentes. Si tiene preguntas, comuníquese con el **Departamento de Servicios Financieros para los Pacientes** al **909/596-7733, anexo 5558**. Las solicitudes se pueden enviar por fax al **909/450-0141.**

Documentos adjuntos: [ ] Solicitud: [ ]

~~Fecha:~~ _____

~~Nombre del paciente/garante:~~ _____

~~Dirección:~~ _____

Llene y brinde toda la información solicitada de la mejor manera posible para que Casa Colina Hospital and Centers for Healthcare pueda determinar con precisión si usted es apto para recibir nuestro Programa de ayuda económica, el cual se basa en las Pautas Federales de Pobreza.

- ✓ Solicitud de ayuda económica llenada y firmada
- ✓ Cartas de otorgamiento para el seguro social, SSI, discapacidad, desempleo, ayuda general, pensión alimenticia, etc.
- ✓ Declaraciones de impuestos más recientes
- ✓ Boletas de pago (las más recientes que tenga)
- ✓ Situación laboral, actual y futura; o, si es trabajador autónomo, declaración de ganancias y pérdidas actuales del año hasta la fecha para determinar el ingreso actual
- ✓ Tamaño de la familia
- ✓ Estados de cuenta bancaria, corretaje e inversiones de los dos últimos meses
- ✓ Copias del formulario 1099 del año calendario pasado con información sobre ingresos por intereses, dividendos, plusvalía, etc.
- ✓ Otros datos financieros pertinentes si no se cuenta con declaraciones de impuestos o boletas de pago. Se excluyen ciertos bienes del paciente, tales como planes de jubilación, casas y automóviles de propiedad del paciente.
- ✓ Verificación del alquiler (renta)
- ✓ Verificación de bienes inmuebles/hipoteca

Tenga en cuenta que cualquier solicitud incompleta será denegada y enviada de vuelta para ser llenada y/o para que se añadan documentos pertinentes. Si tiene preguntas, comuníquese con el **Departamento de Servicios Financieros para los Pacientes** al **909/596-7733, anexo 5558**. Las solicitudes se pueden enviar por fax al **909/450-0141.**

Documentos adjuntos: [ ] Solicitud: [ ]

Solo para usos con fines internos de Casa Colina

Llene la información a continuación antes de entregar la solicitud del solicitante. Si tiene preguntas o dudas, contacte al **Director de Servicios Financieros para los Pacientes** en el anexo

Departamento	
: Número de equipo:	
Fecha de entrega de la solicitud al solicitante:	
Solicitante interno:	

Solo para usos con fines internos de Casa Colina

Llene la información a continuación antes de entregar la solicitud del solicitante. Si tiene preguntas o dudas, contacte al **Director de Servicios Financieros para los Pacientes** en el anexo 5558.

Departament:	
Número de equipo:	
Fecha de entrega de la solicitud al solicitante:	
Solicitante interno:	

Solicitud de ayuda económica

Nombre del paciente: _____ Teléfono: (_____) _____

Dirección: _____ Fecha de nacimiento: _____

_____ Sexo: ☐ Femenino ☐ Masculino

Número de seguro social: _____

SECCIÓN 1: INFORMACIÓN FAMILIAR

Enumere a las personas que viven en su casa que tienen parentesco por nacimiento, matrimonio y/o adopción. Incluya a los estudiantes de la universidad que no viven con la familia pero que reciben apoyo económico.

Nombre	Fecha de nacimiento	Sexo	Relación	Número de seguro social

SECCIÓN 2: INGRESO BRUTO MENSUAL

Enumere a todos los empleadores de cada miembro del hogar y adjunte pruebas de ingreso bruto (antes de los impuestos o deducciones).
Ejemplos de prueba de ingreso: declaración de impuestos sobre la renta o boletas de pago, declaración de ganancias/pérdidas del contador (para los trabajadores autónomos).

Nombre	Nombre del empleador, dirección y teléfono	Ingreso mensual

Enumere todo otro ingreso tal como seguro social, pensión ferroviaria, subsidio de desempleo, indemnización por accidentes laborales, asistencia social/AFDC, ingreso de seguridad complementario, pensión alimenticia para el cónyuge, pensión alimenticia para los hijos, asignación militar, asistencia de un familiar ausente o alguien que no vive en su hogar, pensión privada o pública, pagos del seguro o renta vitalicia, ingresos de dividendos, intereses, alquileres, regalías y/o de bienes raíces o fideicomiso. Adjunte las pruebas de ingresos.

Fuentes de ingreso	Ingreso mensual

Solicitud de ayuda económica

Nombre del paciente: _____ Teléfono: (_____) _____

Dirección: _____ Fecha de nacimiento: _____

_____ Sexo: ☐ Femenino ☐ Masculino

Número de seguro social: _____

SECCIÓN 1: INFORMACIÓN FAMILIAR

Enumere a las personas que viven en su casa que tienen parentesco por nacimiento, matrimonio y/o adopción. Incluya a los estudiantes de la universidad que no viven con la familia pero que reciben apoyo económico.

Nombre	Fecha de nacimiento	Sexo	Relación	Número de seguro social

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SECCIÓN 2: INGRESO BRUTO MENSUAL

Enumere a todos los empleadores de cada miembro del hogar y adjunte pruebas de ingreso bruto (antes de los impuestos o deducciones).
Ejemplos de prueba de ingreso: declaración de impuestos sobre la renta o boletas de pago, declaración de ganancias/pérdidas del contador (para los trabajadores autónomos).

Nombre	Nombre del empleador, dirección y	Ingreso mensual

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Enumere todo otro ingreso tal como seguro social, pensión ferroviaria, subsidio de desempleo, indemnización por accidentes laborales, asistencia social/AFDC, ingreso de seguridad complementario, pensión alimenticia para el cónyuge, pensión alimenticia para los hijos, asignación militar, asistencia de

~~un familiar ausente o alguien que no vive en su hogar, pensión privada o pública, pagos del seguro o renta vitalicia, ingresos de dividendos, intereses, alquileres, regalías y/o de bienes raíces o fideicomiso. Adjunte las pruebas de ingresos.~~

~~Fuentes de ingreso~~	~~Ingreso mensual~~

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SECCIÓN 3: INGRESO MENSUAL

Describa brevemente su situación laboral e incluya la fecha de contratación y/o la última fecha de empleo/jubilación. Si recibe ingresos de otras fuentes, describe el tipo de asistencia, la fecha cuando comenzó y la fecha cuando se prevé que termine, si corresponde. También describa cualquier otro detalle pertinente de sus ingresos.

Identifique TODA fuente de ingreso mensual en su hogar. Enumere a las personas que reciben ingresos y la cantidad que reciben cada mes en cada categoría de ingresos que sea aplicable. Además de llenar esta solicitud, presente todos los documentos requeridos para cada tipo de ingresos que identifique a continuación E incluya la declaración de impuestos más reciente incluyendo TODOS los apéndices correspondientes, estados de cuenta bancaria de dos meses, estados de cuenta de ahorro y estados de cuenta de inversiones/corretaje.

OCUPACIÓN:	Documentos requeridos	Paciente o solicitante	Cónyuge/otro familiar
Salario	2 boletas de pago actuales		
Tarifa por hora			
Promedio de horas laborales mensuales			
Facturación bruta de trabajo autónomo	YTD P&L, Apéndice (1)		
Ingreso de sociedad colectiva	YTD P&L, Apéndice (1)		
Seguro social	Otorgamiento		
Ingreso de seguridad complementario	Otorgamiento		
Desempleo	Otorgamiento		
Discapacidad	Otorgamiento		
Indemnización por accidentes laborales	Otorgamiento		
Ayuda general	Otorgamiento		
Asistencia Temporal para Familias Necesitadas (TANF)	Otorgamiento		
Cupones para Alimentos/Electronic Benefit Transfer (EBT)	Otorgamiento		
Pensión alimenticia para el cónyuge	Otorgamiento		
Pensión alimenticia para los hijos	Otorgamiento		
Préstamo estudiantil	Otorgamiento		
Pensión/renta vitalicia	1099 del año pasado		
Ingresos por intereses	1099 del año pasado		
Dividendos	1099 del año pasado		
Plusvalía	1099 del año pasado		
Ingreso bruto por alquiler			
Otros:			
INGRESO MENSUAL TOTAL			

(1) YTD P&L YTD, P&L significa la declaración de ganancias y pérdidas actuales del año hasta la fecha del negocio o sociedad colectiva. Si su familia no cuenta con ingresos, describa en el espacio a continuación cómo ha podido cubrir sus necesidades de alimento y vivienda. Si otra persona ha estado brindándole ayuda, además de lo que se indica a continuación, pídale a esa persona que envíe a Casa Colina Hospital and Centers for Healthcare una carta describiendo el tipo de ayuda, frecuencia y duración de la ayuda.

~~SECCIÓN 3: INGRESO MENSUAL~~

~~Describa brevemente su situación laboral e incluya la fecha de contratación y/o la última fecha de empleo/jubilación. Si recibe ingresos de otras fuentes, describe el tipo de asistencia, la fecha cuando comenzó y la fecha cuando se prevé que termine, si corresponde. También describa cualquier otro detalle pertinente de sus ingresos.~~

~~Identifique TODA fuente de ingreso mensual en su hogar. Enumere a las personas que reciben ingresos y la cantidad que reciben cada mes en cada categoría de ingresos que sea aplicable. Además de llenar esta solicitud, presente todos los documentos requeridos para cada tipo de ingresos que identifique a continuación E incluya la declaración de impuestos más reciente incluyendo TODOS los apéndices correspondientes, estados de cuenta bancaria de dos meses, estados de cuenta de ahorro y estados de cuenta de inversiones/corretaje.~~

~~OCUPACIÓN~~:	~~Documentos requeridos~~	~~Paciente o~~	~~Cónyuge/otro familiar~~
~~Salario~~	~~2 boletas de pago~~		
~~Tarifa por hora~~			
~~Promedio de horas laborales mensuales~~			
~~Facturación bruta de trabajo autónomo~~	~~YTD P&L, Apéndice~~		
~~Ingreso de sociedad colectiva~~	~~YTD P&L, Apéndice~~		
~~Seguro social~~	~~Otorgamiento~~		
~~Ingreso de seguridad complementario (SSI)~~	~~Otorgamiento~~		
~~Desempleo~~	~~Otorgamiento~~		
~~Discapacidad~~	~~Otorgamiento~~		
~~Indemnización por accidentes laborales~~	~~Otorgamiento~~		
~~Ayuda general~~	~~Otorgamiento~~		
~~Asistencia Temporal para Familias~~	~~Otorgamiento~~		
~~Cupones para Alimentos/Electronic Benefit~~	~~Otorgamiento~~		
~~Pensión alimenticia para el cónyuge~~	~~Otorgamiento~~		
~~Pensión alimenticia para los hijos~~	~~Otorgamiento~~		
~~Préstamo estudiantil~~	~~Otorgamiento~~		
~~Pensión/renta vitalicia~~	~~1099 del año~~		
~~Ingresos por intereses~~	~~1099 del año~~		
~~Dividendos~~	~~1099 del año~~		
~~Plusvalía~~	~~1099 del año~~		
~~Ingreso bruto por alquiler~~			
~~Otros:~~			
~~INGRESO MENSUAL TOTAL~~			

~~(2) YTD P&L YTD, P&L significa la declaración de ganancias y pérdidas actuales del año hasta la fecha del negocio o sociedad colectiva. Si su familia no cuenta con ingresos, describa en el espacio a continuación cómo ha podido cubrir sus necesidades de alimento y vivienda. Si otra persona ha estado brindándole~~

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~~ayuda, además de lo que se indica a continuación, pídale a esa persona que envíe a Casa Colina Hospital and Centers for Healthcare una carta describiendo el tipo de ayuda, frecuencia y duración de la ayuda.~~

SECCIÓN 4: GASTOS MENSUALES	Paciente o solicitante	Cónyuge/otro familiar
Hipoteca de residencia ocupada por el dueño		
Hipoteca de propiedad en alquiler		
Alquiler (renta)		
Impuestos prediales (inmobiliarios)		
Pagos por automóvil		
Cuidado de niños		
Teléfono celular		
Alimentos y artículos para el hogar		
Seguro de automóviles y gasolina		
Ropa		
Gastos médicos y dentales		
Seguro		
Pago de tarjetas de crédito		
Pago (matrícula y clases) de estudios		
Pensión alimenticia para los hijos		
Pensión alimenticia para el cónyuge		
Pagos fraccionados		
Gastos de lavado de ropa y limpieza		
Otros:		
GASTOS MENSUALES TOTALES		

Si los gastos mensuales reportados exceden los ingresos reportados, explique cómo puede cumplir con estas obligaciones económicas.

____

____

Indique si el paciente ha solicitado en ingreso en Medi-Cal o cualquier otro programa gubernamental. Si es así, brinde la información que figura a continuación:

Nombre del programa: ____

Número de póliza/identificación: ____________________________________

Fecha del programa: ____

Otros: ____

____

____

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Si los gastos mensuales reportados exceden los ingresos reportados, explique cómo puede cumplir con estas obligaciones económicas.

Indique si el paciente ha solicitado en ingreso en Medi-Cal o cualquier otro programa gubernamental. Si es así, brinde la información que figura a continuación:

Nombre del programa:

N.° de póliza/identificación:

Fecha del programa:

Otros:

SECCIÓN 5: OTROS

¿Usted trabaja? ☐ Yes ☐ No ¿Trabajará en el futuro? ☐ Sí ☐ No

¿Se ha declarado en bancarrota? ☐ Sí ☐ No ¿Cuándo?

Incluya también cualquier información que considere útil o indique lo que crea importante que podría ayudarnos a evaluar su solicitud.

_____

_____

_____

OBJETIVO: El objetivo de esta información es determinar su capacidad para pagar los servicios de Casa Colina Hospital and Centers for Healthcare o su posible aptitud para recibir un programa de ayuda médica. Esta información NO es una solicitud para Medi-Cal, County Medically Indigent Services Program, California Children Services, Healthy Families ni ningún otro programa de ayuda en el condado.

DEBE CONTACTAR AL DEPARTAMENTO DE SERVICIOS SOCIALES DE SU CONDADO DE RESIDENCIA PARA SOLICITAR EL INGRESO EN PROGRAMAS DE AYUDA.

Certifico que la información anterior es precisa y completa y que estoy presentando esta solicitud a Casa Colina and Centers for Healthcare para determinar mi aptitud para recibir atención médica con descuento o atención benéfica. Comprendo que Casa Colina Hospital and Centers for Healthcare se reserva el derecho de verificar toda la información brindada, incluido el permiso para contactar a empleadores y verificar mis/nuestros antecedentes crediticios. Acepto notificar al Departamento de Contabilidad de esta entidad sobre cualquier cambio en mi información financiera en el plazo de 10 días del cambio.

COMPRENDO QUE YO PODRÍA SEGUIR SIENDO RESPONSABLE DEL MONTO COMPLETO DE LOS CARGOS EN CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE.

Firma del paciente/parte responsable:

_____

Nombre en letra de imprenta:

_____

Nombre en letra de imprenta:

_____

Fecha: _____

Fecha: _____

FINANCIAL ASSISTANCE REQUEST **EXHIBIT C**
CASA COLINA USE ONLY

Date: _____

[ ] Free Care / Via Foundation
(Do Not Qualify for Charity Care)

[ ] Charity Care / Uncompensated Care Request
(Per Federal Poverty Guideline in CCH policy)

[ ] Discounted Care

[ ] Medicare Bad Debt

[ ] Wounded Warrior

(Applicable only after 120 days of Medicare RA and collections efforts; Medicare balances do not qualify for Charity Care cost reporting.)

Team: _____ **Corporation:** _____ **Requested by:** _____

Patient Name:
_____

Social Security Number:
_____
Diagnosis:
_____

Requested Uncompensated Care: $ _____ = _____ days/visits (LOS)

Requested Discounted: $
_____

JUSTIFICATION:

ELIGIBILITY: _____ Approved _____ Disapproved _____ Partial (_____%)

Eligible for $_____, _____ days/visits (LOS)

By: _____ Date: _____

Comments: _____

AUTHORIZATION: _____ Approved _____ Disapproved _____ Partial (_____)

By: Chief Financial Officer _____ Date _____

_____ Approved _____ Disapproved
By: Chief Planning & Development Officer _____ Date _____

Approved Disapproved

By: President and CEO Date

~~JUSTIFICATION:~~

~~_____ . . _____ Disapproved _____ Partial (_____%)~~

~~Eligible for $_____, _____ days/visits (LOS)~~

~~By: _____ Date:~~

~~Comments:~~

~~AUTHORIZATION: _____ Approved _____ Disapproved _____ Partial (_____)~~

~~By: Chief Financial Officer _____ Date~~

~~_____ Approved _____ Disapproved~~
~~By: Chief Planning & Development Officer _____ Date~~

~~_____ Approved _____ Disapproved~~
~~By: President and CEO _____ Date~~

Casa Colina Hospital and Centers for Healthcare
Financial Assistance Policy Plain Language Summary

Who is eligible?
A patient may be eligible for discounted care if family income is at or below 400% of the Federal Poverty Level. Charity care is available if family income is at or below 200% of the Federal Poverty Level. If family income is between 201% and 400% of the Federal Poverty Level, then a portion of the bill may be forgiven.

What does the Financial Assistance Policy cover?
The Financial Assistance Policy covers medically necessary healthcare services provided at Casa Colina Hospital and Centers for Healthcare. Physician services are excluded from Casa Colina Hospital and Centers for Healthcare's Financial Assistance Policy.

How to apply:
To obtain our Financial Assistance Policy and Financial Assistance Application online, please visit www.casacolina.org/financialassistance. Paper copies are also available in the Admitting and Registration Departments throughout the facility located at 255 E. Bonita Ave., Pomona, CA 91767. If you would like a copy sent to you via U.S. mail, please call 909/596-7733, ext. 5558. The application is available in English and Spanish.

Once the application is complete, please mail to P.O. Box 6001, Pomona, CA 91769-6001 or fax to 909/450-0141with all applicable documentation listed below.

Required

- Completed and signed Financial Assistance Application
- Pay stubs (most recent available within past 6 months)
- Federal Income Tax Return (e.g. Form 1040)
- ~~–~~

Optional

- Award letters for Social Security, Supplemental Security Income (SSI), Disability, Unemployment, General Relief, Alimony, etc.
- Family income from all sources (including tax returns)
- ~~Pay stubs (most recent available)~~
- Employment status, both current and future; or, if self- employed, current year-to-date profit and loss statement to determine current income
- Family size
- Last two months' bank, brokerage, and investment statements
- Copies of last calendar year's 1099 for interest income, dividends, capital gains, etc.
- Other appropriate financial data if tax returns or pay stubs are not available. Certain patient's assets - such as retirement plans, homes, and automobiles owned by the patient - are excluded.
- Rent verification
- Property/mortgage verification

Failure to provide required documentation may delay the application process or cause your application to be denied. Complete application and documentation are necessary to determine

eligibility. If you have questions or need assistance completing the application, please call 909/596-7733, ext. 5558.

EXHIBIT E

FINANCIAL WORKSHEET AND
2026 FINANCIAL POVERTY GUIDELINES - CASA COLINA DISCOUNT PERCENTAGE

Persons In Household	Federal Poverty Guidelines		Between 100%		And 200%	
1	$15,960		$15,960		$31,920	
2	$21,640		$21,640		$43,280	
3	$27,320		$27,320		$54,640	DISCOUNT
4	$33,000		$33,000		$66,000	**100%**
5	$38,680		$38,680		$77,360	
6	$44,360		$44,360		$88,720	
7	$50,040		$50,040		$100,080	
8	$55,720		$55,720		$111,440	

Persons In Household	Federal Poverty Guidelines		Between 201%		And 250%	
1	$15,960		$31,922		$39,900	
2	$21,640		$43,282		$54,100	
3	$27,320		$54,643		$68,300	DISCOUNT
4	$33,000		$66,003		$82,500	**75%**
5	$38,680		$77,364		$96,700	
6	$44,360		$88,724		$110,900	
7	$50,040		$100,085		$125,100	
8	$55,720		$111,446		$139,300	

EXHIBIT E

FINANCIAL WORKSHEET AND
2026 FINANCIAL POVERTY GUIDELINES - CASA COLINA DISCOUNT PERCENTAGE

Persons In Household	Federal Poverty Guidelines		Between 251%		And 300%	
1	$15,960		$39,902		$47,880	
2	$21,640		$54,102		$64,920	
3	$27,320		$68,303		$81,960	DISCOUNT
4	$33,000		$82,503		$99,000	**50%**
5	$38,680		$96,704		$116,040	
6	$44,360		$110,904		$133,080	
7	$50,040		$125,105		$150,120	
8	$55,720		$139,306		$167,160	

Persons In Household	Federal Poverty Guidelines		Between 301%		And 400%	
1	$15,960		$47,882		$63,840	
2	$21,640		$64,922		$86,560	
3	$27,320		$81,963		$109,280	DISCOUNT
4	$33,000		$99,003		$132,000	**25%**
5	$38,680		$116,044		$154,720	
6	$44,360		$133,084		$177,440	
7	$50,040		$150,125		$200,160	
8	$55,720		$167,166		$222,880	

EXHIBIT F

Public Notice

Help Paying Your Bill

Charity Care – Financial assistance is available to patients who are unable to pay their hospital bill with family income at or below 200% of the Federal Poverty Level. This is available to patients receiving medically necessary services and who meet the qualifications of the hospital's Patient Financial Assistance Policy.

Discounted Care - Patients who are not eligible for charity care due to the patient's family income being between 201% and 400% of the established Federal Poverty level may be eligible for discounted care.

How To Apply

To see if you qualify for financial assistance, complete a financial assistance application. To view the Financial Assistance Application, Policy, and Plain Language Summary, please go to https://www.casacolina.org/patients-families/help-paying-your-bill/. Please contact Patient Financial Services at (909) 596-7733, ext. 5558 if you have questions or need assistance completing the Financial Assistance Application.

More Help

There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888804-3536 or go to healthconsumer.org for more information.

If you need help in your language, please call 909-596-7733 or visit the Admissions Office. The office is open 8-5pm and located at 255 E. Bonita Ave, Pomona CA 91767. Aids and services for people with disabilities, like documents in braille, large print, audio, and other accessible electronic formats are also available. These services are free.

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 you 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~~If you are uninsured or underinsured, you may qualify for the Financial Assistance Program. Paper copies of the Financial Assistance Program are available upon request. Please contact the Admissions or Registration Departments or call the Patient Accounting Department at 909/596-7733, ext. 5558 or online at .~~


CASA COLINA
Hospital and Centers for Healthcare

Notificacion Publica

Ayuda para pagar su factura
Atención caritativa – Hay asistencia financiera disponible para los pacientes que no pueden pagar su factura hospitalaria y cuyo ingreso familiar se encuentra en un 200% o menos del Nivel Federal de Pobreza. Esta asistencia está disponible para los pacientes que reciben servicios médicamente necesarios y que cumplen con los requisitos de la Política de Asistencia Financiera al Paciente del hospital.
Atención con descuento – Los pacientes que no reúnen los requisitos para la atención caritativa debido a que su ingreso familiar se sitúa entre el 201% y el 400% del Nivel Federal de Pobreza establecido podrían ser elegibles para recibir atención con descuento.

Cómo solicitar ayuda
Para determinar si califica para recibir asistencia financiera, complete una solicitud de asistencia financiera. Para consultar la Solicitud de Asistencia Financiera, la Política y el Resumen en Lenguaje Sencillo, visite https://www.casacolina.org/patients-families/help-paying-your-bill/. Comuníquese con el Departamento de Servicios Financieros para Pacientes al (909) 596-7733, ext. 5558, si tiene preguntas o necesita ayuda para completar la Solicitud de Asistencia Financiera.

Más ayuda
Existen organizaciones gratuitas de defensa del consumidor que le ayudarán a comprender el proceso de facturación y pago. Puede llamar a la Health Consumer Alliance al 888-804-3536 o visitar healthconsumer.org para obtener más información.
Si necesita ayuda en su idioma, por favor llame al 909-596-7733 o visite la Oficina de Admisiones. La oficina está abierta de 8:00 a. m. a 5:00 p. m. y se encuentra en 255 E. Bonita Ave, Pomona, CA 91767. También están disponibles ayudas y servicios para personas con discapacidades, tales como documentos en braille, letra grande, audio y otros formatos electrónicos accesibles. Estos servicios son gratuitos.

Programa de Quejas sobre Facturas Hospitalarias
El Programa de Quejas sobre Facturas Hospitalarias es un programa estatal que revisa las decisiones de los hospitales con respecto a si usted califica para recibir ayuda para pagar su factura hospitalaria. Si considera que se le denegó la asistencia financiera de manera incorrecta, puede presentar una queja ante el Programa de Quejas sobre Facturas Hospitalarias. Visite HospitalBillComplaintProgram.hcai.ca.gov para obtener más información y para presentar una queja.
~~Si usted no tiene cobertura de seguro médico, podrá calificar para el Programa de Ayuda Económica. Las copias en papel del Programa de Ayuda Económica están a disposición de los interesados. Comuníquese con los Departamentos de Ingreso o Inscripción, llame al Departamento de Contabilidad al (909) 596-7733, ext. 5558 o visite la página web www.casacolina.org/financialassistance.~~

Exhibit F – Public Notice of the Availability of Discount/Charity Care Programs (English & Spanish)
Reviewed 11/18/21, 1/2022; Revised 5/2026

EXHIBIT G

Copy of the Conditions of Admission and Patient Handbook

Casa Colina Hospital and Centers for Healthcare is proud of its goal to provide quality care to all who need it regardless of ability to pay.

If you do not have health insurance and worry that you may not be able to pay in full for your care, we may be able to help. Casa Colina provides financial assistance to patients based on their income and needs. We may be able to help you get financial coverage or work with you to arrange a manageable payment plan.

It important that you let us know if you will have trouble paying your bill; federal and state laws require health organizations make reasonable efforts to collect payment for services from patients/clients. The organization may turn unpaid bills over to a collection agency, which could affect your credit status. We would like to work with you to avoid this situation.

For more information, please contact our Patient Accounting office at 909/596-7733, ext. 5558. We will treat your questions with confidentiality and courtesy.

Patient Name: _____ MR#: _____
Date of Birth: _____

NOTIFICACION PARA EL PACIENTE / CLIENTE SOBRE ASISTENCIA FINANCERIA

Casa Colina Hospital y Centros de Salud está orgulloso de su misión de proporcionar atención de calidad a todos los que necesitan independientemente de la capacidad de pago.

Si usted no tiene seguro médico y tiene preocupaciones que no puede pagar por su cuidado , o servicios, cabe la posibilidad que le podemos ayudar. Casa Colina Hospital y Centros de Salud proporciona ayuda financiera a los pacientes basados en sus ingresos y necesidades. Quizás puedamos ayudarle a conseguir la cobertura financiera, o trabajar con usted para organizar un plan de pagos manejable.

Es importante que usted nos haga saber si usted tendra dificultad en pagar su cuenta; las leyes federales y del estado requieren a organizaciones médicas que hagan esfuerzos razonables para recuperar fondos por servicios a pacientes/clientes. La organización puede mandar cuentas no pagadas a una agencia de colección, que puede afectar su estado de crédito. Quisieramos trabajar con usted para evitar esta situación.

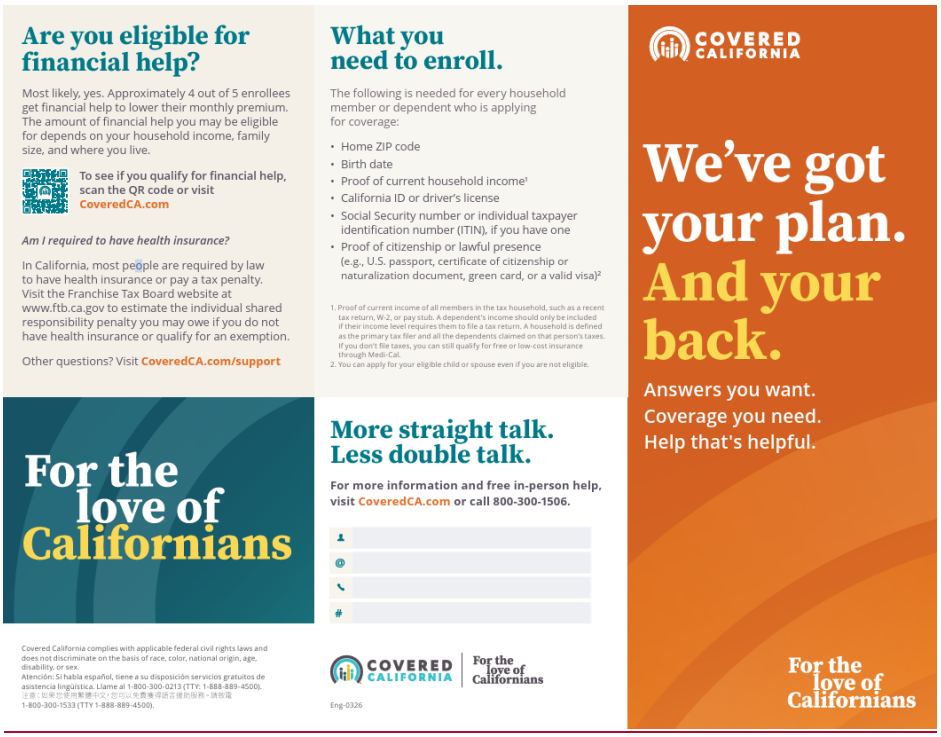
Para mas información, por favor comuniquese con nuestra oficina de Servicios al Paciente a (909) 596-7733 ext. 5558. Trataremos sus preguntas en confianza y con cortesía.

Nombre de Paciente: _____ MR#: _____

Fecha de Nacimiento: _____

EXHIBIT H

COVERED CALIFORNIA FACT SHEET (ENGLISH)



Are you eligible for financial help?

Most likely, yes. Approximately 4 out of 5 enrollees get financial help to lower their monthly premium. The amount of financial help you may be eligible for depends on your household income, family size, and where you live.

To see if you qualify for financial help, scan the QR code or visit CoveredCA.com

Am I required to have health insurance?

In California, most people are required by law to have health insurance or pay a tax penalty. Visit the Franchise Tax Board website at www.ftb.ca.gov to estimate the individual shared responsibility penalty you may owe if you do not have health insurance or qualify for an exemption.

Other questions? Visit **CoveredCA.com/support**

What you need to enroll.

The following is needed for every household member or dependent who is applying for coverage:

- Home ZIP code
- Birth date
- Proof of current household income[1]
- California ID or driver's license
- Social Security number or individual taxpayer identification number (ITIN), if you have one
- Proof of citizenship or lawful presence (e.g., U.S. passport, certificate of citizenship or naturalization document, green card, or a valid visa)[2]

1. Proof of current income of all members in the tax household, such as a recent tax return, W-2, or pay stub. A dependent's income should only be included if their income level requires them to file a tax return. A household is defined as the primary tax filer and all the dependents claimed on that person's taxes. If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal.
2. You can apply for your eligible child or spouse even if you are not eligible.

COVERED CALIFORNIA

We've got your plan. And your back.

Answers you want.
Coverage you need.
Help that's helpful.

For the love of Californians

For the love of Californians

More straight talk. Less double talk.

For more information and free in-person help, visit CoveredCA.com or call 800-300-1506.

Covered California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Atención: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-300-0213 (TTY: 1-888-889-4500).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-300-1533 (TTY 1-888-889-4500).

COVERED CALIFORNIA | For the love of Californians

Eng-0326

COVERED CALIFORNIA

See if you can get help paying for your health insurance

Covered California is where you can get quality, affordable health coverage. You may even get help paying for it.

As part of the Affordable Care Act (ACA), Covered California is a program where lawfully present Californians and their families can compare quality health plans and choose the one that works best for their health needs and budget. Covered California is the only place where you can get financial help to pay for your health insurance.

Are you eligible? Find out here.

Maximum Annual Household Income to Qualify for Financial Help

FAMILY SIZE	MEDI-CAL	COVERED CALIFORNIA
1	$16,754	$48,560
2	$22,715	$65,840
3	$28,677	$83,120
4	$34,638	$100,400
5	$40,600	$117,680
6	$46,652	$134,960
	You may be eligible for low or no-cost Medi-Cal.	*You may be eligible for financial help through Covered California.*

All numbers listed above are estimates. For larger households, please visit the Shop and Compare tool at CoveredCA.com to find out if your family qualifies.

Your notes:

Enrollment deadlines

FOR COVERAGE EFFECTIVE ON	COMPLETE ENROLLMENT BY	PAY YOUR PREMIUM
January 1, 2019	December 15, 2018	Make sure to pay your first bill on time, and continue to make monthly payments by the due date on your invoice.
February 1, 2019	January 15, 2019	

Even if you only need coverage for just a few months, look to Covered California throughout the year for your health insurance needs. Medi-Cal enrollment is year-round.

Have questions? We can help. **CoveredCA.com | 800.300.1506**

EXHIBIT H

COVERED CALIFORNIA FACT SHEET (SPANISH)

COVERED CALIFORNIA

Averigua si puedes obtener ayuda para pagar tu seguro médico

Covered California es el lugar donde puedes obtener cobertura de salud de calidad y a bajo costo. Hasta podrías obtener ayuda para pagarla.

Como parte de la Ley de Cuidado de Salud a Bajo Precio (ACA, por sus siglas en inglés), Covered California es un programa donde la mayoría de los residentes legales de California y sus familias pueden comparar planes de salud de calidad y elegir el que mejor se ajuste a sus necesidades de salud y presupuesto. Covered California es el único lugar en donde puedes obtener ayuda económica para pagar tu seguro médico.

Tus notas:

¿Calificas? Entérate aquí.

Ingreso familiar anual máximo para calificar para ayuda económica

TAMAÑO FAMILIAR	MEDI-CAL	COVERED CALIFORNIA
1	$16,754	$48,560
2	$22,715	$65,840
3	$28,677	$83,120
4	$34,638	$100,400
5	$40,600	$117,680
6	$46,652	$134,960
	Podrías calificar para Medi-Cal a bajo o sin costo alguno.	*Podrías calificar para ayuda económica a través de Covered California.*

Las cantidades mostradas son solo estimaciones. Para familias más grandes, visita la herramienta de Buscar y Comparar en CoveredCA.com/espanol para saber si tu familia califica.

Fechas límites de inscripción

PARA QUE LA COBERTURA EMPIECE EL	COMPLETA TU INSCRIPCIÓN ANTES DEL	PAGA TU PRIMA
1 de enero de 2019	15 de diciembre de 2018	Asegúrate de pagar tu primera factura a tiempo y continúa haciendo los pagos mensuales antes de la fecha de vencimiento en tu factura.
1 de febrero de 2019	15 de enero de 2019	

Aun si solo necesitas cobertura durante pocos meses, Covered California está disponible todo el año para atender tus necesidades de seguro de salud. La inscripción en Medi-Cal es todo el año.

¿Tienes preguntas? Te podemos ayudar. **CoveredCA.com/espanol | 800.300.0213**

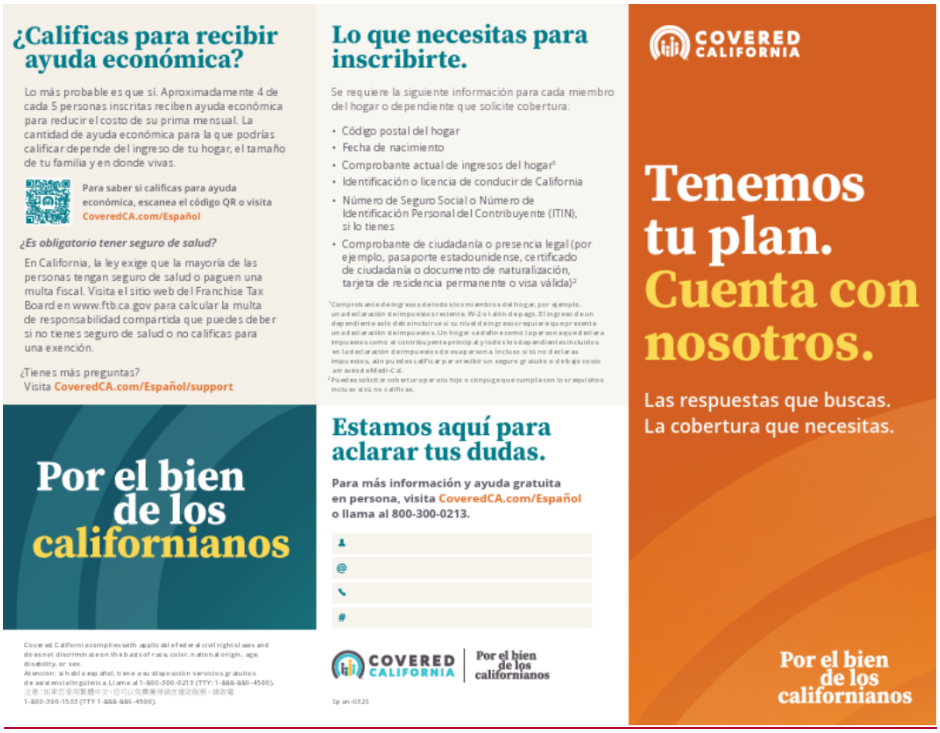


Exhibit H – Covered California Fact Sheet (English & Spanish)
Reviewed 11/18/21, 1/2022; Revised 1/2026

EXHIBIT I

COUNTY OF LOS ANGELES DHCS LIST OF LOCAL PROGRAMS (ENGLISH)

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

YOU CAN GET NO-COST OR LOW-COST MEDICAL CARE

AT ANY LA COUNTY CLINIC OR HOSPITAL IF YOU ARE ELIGIBLE FOR ONE OF THE PROGRAMS BELOW

Program	Who Can Get it?	How Much Does It Cost?	What Care Is Covered?	Where Do I Go for Care?
Ability to Pay (ATP) *The former ORSA is now part of ATP*	Los Angeles County residents who do not qualify for Medi-Cal, or Medicare	• No-Cost for persons with incomes at or under 138% FPL • Low-Cost for those over 138% FPL	• Clinic and outpatient hospital visits • Tests and medicines • Inpatient hospital care • Emergency Room (ER) visits • Certain surgeries	ONLY • County hospitals • County clinics
Pre-Payment Plan	Los Angeles County residents	• A low-cost, flat fee for each visit, if paid within 7 days of choosing Pre-Payment Plan	• Clinic and outpatient hospital visits • Tests only • ER visits • Certain outpatient surgeries *Does not include hospital inpatient care or medicine you take home*	ONLY • County hospitals • County clinics
Discount Payment Plan	Non-County residents who • have no insurance or have high medical costs even with insurance • do not qualify for Medi-Cal; income is at or under 350% FPL	• A 5% discount off charges or what Medi-Cal would pay (whichever is less)	• Inpatient hospital care and outpatient hospital visits • Emergency Room (ER) visits	ONLY • County hospitals
Specialty No-Cost or Low-Cost Programs				
County Mental Health Services (Short Doyle)	Persons needing mental health treatment who • Do not qualify for Medi-Cal • Are functionally disabled by severe and persistent mental illness or who are seriously emotionally disturbed	• One amount for the whole year • Varies, depending on family size, resources and income	• Inpatient hospital care • Outpatient mental health care	• Call the L.A. County Department of Mental Health at 800-854-7771 to find a county mental health facility
Child Delivery Plan	• Pregnant women who are Los Angeles County residents • Each mother must apply for Medi-Cal for her baby	• $2,000 flat fee paid within 7 days after leaving the hospital	• All labor and delivery services	ONLY • County hospitals
Dialysis; TB; Post-Polio	• Dialysis & Post-Polio: California residents • TB: No residency requirement	• Low-Cost fees	• Care for kidney disease, inpatient tuberculosis care, and post-polio related services	ONLY • County hospitals • County clinics
No Extra Cost Medicines	Los Angeles County residents who are outpatient clinic patients	• No-Cost	• Medicine for emergency and public health services	ONLY • County hospitals • County clinics

Who Can Apply for No-Cost or Low-Cost programs in LA County?	
Minimum requirements	Patients must be a Los Angeles County resident and provide acceptable proof that you live in Los Angeles County (ID and proof of address or statement certifying homelessness) and must have medical costs that Medi-Cal, Medicare, private insurance or other benefits won't pay.
What is income at 138% of the Federal Poverty Level (FPL)?	Income is based on your family size. **For 2018, 138% FPL monthly income is $1,397 for a family of one; $1,893 for two; $2,390 for three; $2,887 for four; $3,384 for five; $3,881 for six; $4,377 for seven; $4,874 for eight; $5,371 for nine; $5,868 for ten.** For families larger than ten, add about **$497** per person. For pregnant women count the woman and the number of expected babies. A county worker will see if your income qualifies for these programs and the amount you must pay.
Can non-LA County residents still receive low-cost care?	**Yes, non-LA County residents may receive a discount on their cost for care at LA County hospital under the Discount Payment Plan if they have income at or under 350% FPL.** *Only LA County residents may get no-cost medical care.*

For more information and where to apply, go to www.dhs.lacounty.gov - see the back of this sheet for L.A. County locations

EXHIBIT I

COUNTY OF LOS ANGELES DHCS LIST OF LOCAL PROGRAMS (ENGLISH)

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

Additional information about No-Cost or Low-Cost programs in LA County	
How to apply for ATP	**ATP:** Patients apply for ATP during a financial screening appointment at one of the hospitals and clinics listed below. The amount you must pay, if anything is based on your income. The application is good for one year.
What are payments for ATP?	ATP now covers inpatient and outpatient care with one agreement. The former ORSA program is part of ATP. If you have questions about the change, see a financial services worker. • Patients whose incomes after deductions are above 138% FPL pay a low-cost for services. • Patients pay **one amount** for each inpatient admission, regardless of how long the patient stays in the hospital. • Patients only pay one amount **each month** for outpatient care, regardless of how many outpatient visits the patient has in a month. • General Relief patients always get care at no-cost.
Can I use ATP for services not covered by other programs?	**Yes** - You may use ATP for services not covered by Medi-Cal, Medicare or private insurance. • ATP will cover your deductible for private insurance, but it doesn't cover Medicare deductibles or Medi-Cal share of cost.
Can I get more time for payments?	**Yes** – If you are in the ATP or Out-of-County programs and cannot pay the amount you owe within 30 days, you may make arrangements to pay it over a longer period of time. Our extended payment plan bases how long you have to pay on your income, resources and family size.
Do I have to apply for Medi-Cal before I get a County No-Cost/Low-Cost Program?	**Yes** - If a County worker determines that you may qualify for Medi-Cal. Also, new mothers using the Child Delivery Plan must apply for Medi-Cal for their baby. *If you do not fully cooperate with the Medi-Cal application process, you cannot get ATP, Discount Payment or Child Delivery Plan.* **No** - If using Pre-Payment, you do not have to apply for Medi-Cal. Pregnant women who use the Child Delivery Plan do not have to apply for Medi-Cal.
Pre-Payment Amounts	$60 for prenatal visits for the first 7 visits, the rest are at no-cost; $60 for clinic visits at Comprehensive Health Centers (CHC) and Health Centers (HC); $80 for clinic visits at county hospital clinics, MLK Outpatient Center, & High Desert Regional HC $80 for urgent care visits at all locations; $140 at county hospital emergency rooms; $500 at outpatient surgery clinics.
Is my immigration status affected by using these programs?	The County does **NOT** report patients to US Citizenship and Immigration Services. US Citizenship and Immigration Services will **Not** consider you a public charge if you use the No-Cost or Low-Cost Programs.
What happened to Healthy Way LA?	Healthy Way LA (HWLA) ended on 12/31/13, Medi-Cal now covers those people that would have been eligible for the HWLA. If you had HWLA and do not now have Medi-Cal, please see a county worker.

FOR MORE INFORMATION AND WHERE TO APPLY FOR NO-COST OR LOW-COST CARE IN LA COUNTY

Hospitals

Harbor/UCLA Medical Center
Patient Financial Services
1000 West Carson St. Bldg. 3-South
Torrance 90509
(310) 222-3012

LAC+USC Medical Center
1100 N. State St.
T-17 – Billing Inquiry
Los Angeles 90033
(323) 409-6361

Olive View/UCLA Medical Center
14445 Olive View Dr.
2nd Floor, Room 2D151
Sylmar 91342
(747) 210-4154

Rancho Los Amigos National Rehabilitation Center
7601 E. Imperial Hwy. Bldg.602
Downey 90242
(562) 385-7320

Clinics

Antelope Valley Health Center
335-B E. Ave. K-6
Lancaster 93535
Member Services
(661) 471-4147
(661) 471-4000

Bellflower Health Center
10005 E. Flower St.
Bellflower 90706
(562) 526-3000

Dollarhide Health Center
1108 N. Oleander
Compton 90220
(310) 763-2244

El Monte Comp. Health Center
10953 Ramona Boulevard
El Monte 91731
(626) 434-2500

Glendale Health Center
501 N. Glendale Ave.
Glendale 91206
(818) 291-8900

H. Claude Hudson Comp. Health Center.
2829 South Grand Ave.
Los Angeles 90007
(213) 699-7000

H.H. Humphrey Comp. Health Center
5850 So. Main St.
Los Angeles 90003
(323) 897-6000

Harbor/UCLA Family Health Center
1403 West Lomita Blvd., 2nd Floor
Harbor City, 90710
(310) 534-7600

Lake Los Angeles Clinic
16921 E. Avenue 0, Space G
Lake Los Angeles 93535
(661) 471-4000

La Puente Health Center
15930 Central Ave.
La Puente 91744
(626) 986-2900

Littlerock Community Clinic
8201 Pearblossom Hwy.
Littlerock 93543
(661) 471-4000

Long Beach Comp. Health Center.
1333 Chestnut Ave.
Long Beach 90813
(562) 753-2300

Mid Valley Comp. Health Center
7515 Van Nuys Blvd.
Van Nuys 91405
(818) 627-3000

San Fernando Health Center
1212 Pico St.
San Fernando 91340
(818) 627-4777

South Valley Health Center
38350 40th St. East
Palmdale 93550
(661) 471-4000

Wilmington Health Center
1325 Broad Ave.
Wilmington 90744
(310) 404-2040

Martin Luther King, Jr. Outpatient Center
1670 East 120th St.
Los Angeles 90059
(424) 338-1817

High Desert Regional Health Center
335 East Ave I
Lancaster 93536
(661) 471-4000

E. R. Roybal Comp. Health Center
245 S. Fetterly Ave.
Los Angeles 90022
(323) 362-1010

EXHIBIT I

COUNTY OF LOS ANGELES DHCS LIST OF LOCAL PROGRAMS (SPANISH)

COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES

USTED PUEDE OBTENER ATENCIÓN MEDICA SIN COSTO O A BAJO COSTO

EN CUALQUIER CLÍNICA O HOSPITAL DEL CONDADO DE LOS ANGELES SI USTED ÉS ELEGIBLE PARA UNOS DE ESTOS PROGRAMAS

Programa	¿Quién lo puede obtener?	¿Cuánto cuesta?	¿Qué servicios cubre?	¿A dónde voy para servicio médico?
Habilidad de Pago (ATP) *El programa anterior de ORSA ahora es parte de ATP*	Residentes del Condado de Los Ángeles quienes no califiquen para Medi-Cal, o Medicare	• Sin costo para las personas con ingresos a o a menos del 138% FPL • Bajo costo para las personas con ingresos más del 138% FPL	• Visitas a clínicas y visitas de hospital para pacientes externos • Análisis (pruebas) y medicamentos • Hospitalizaciones • Visitas a sala de emergencia • Ciertas cirugías	**Solamente:** • Hospitales del Condado • Clínicas del Condado
Plan de Pago por Adelantado	Residentes del Condado de Los Ángeles	• Un bajo costo, una tarifa fija por visita, si es pagado dentro de siete (7) días después de haber elegido el Plan de Pago por Adelantado	• Visitas a clínicas y visitas de hospital para pacientes externos • Análisis (pruebas) solamente • Visitas a sala de emergencia • Ciertas cirugías de consulta externa *No incluye hospitalización o medicinas que lleve a casa*	**Solamente:** • Hospitales del Condado • Clínicas del Condado
Plan de Descuento de Pagos	Personas que no son residentes del Condado de Los Ángeles • Que no tiene seguro médico o tengan costos altos aun con seguro medico • Que no califiquen para Medi-Cal • Con ingresos a o a menos del 350% FPL	• Un descuento de 5% de los costos o la cantidad que el Medi-Cal pagaría (la cantidad que sea menor)	• Hospitalizaciones • Visitas a sala de emergencia	**Solamente:** • Hospitales del Condado
Programas Sin Costo o A Bajo Costo Especializados				
Servicios de Salud Mental del Condado	Personas que necesitan tratamiento de salud mental • Que no califiquen para Medi-Cal • Que están funcionalmente discapacitado por enfermedad mental grave y persistente o que estén seriamente perturbadas emocionalmente	• Una cantidad para todo el año • El costo es variable, dependiendo de los recursos e ingresos y número de miembros de la familia	• Hospitalizaciones • Visitas a clínicas de Salud Mental	**Solamente:** • Hospitales del Condado
Plan de Maternidad	• Mujeres embarazadas que son residentes del Condado de Los Ángeles • Cada madre tiene que aplicar para Medi-Cal para su bebé	• $2,000 tarifa fija pagada dentro de 7 días después de salir del hospital	• Todos los servicios de parto	**Solamente:** • Hospitales del Condado
Diálisis del Riñón, Tuberculosis (TB) y Post Polio	• Diálisis y Post Polio: residentes de California • TB: No requiere residencia	• Tarifas a bajo costo	• Tratamiento para enfermedad de riñón, cuidado de hospitalización de tuberculosis, y servicios relacionados con el cuidado de Post Polio	**Solamente:** • Hospitales del Condado • Clínicas del Condado
Medicinas sin Costo Adicional	Residentes del Condado de Los Angeles que son pacientes de las clínicas de paciente externo	• Sin costo	• Medicina de emergencia y servicios de salud pública	**Solamente:** • Hospitales del Condado • Clínicas del Condado
¿Quién Puede Solicitar los Programas Sin Costo o A Bajo Costo en el Condado de Los Angeles?				
Requisitos Mínimos	Pacientes tienen que ser residentes del Condado de Los Ángeles y demostrar comprobantes aceptables de residencia del Condado de Los Ángeles (identificación y comprobante de domicilio o declaración que certifique falta de hogar) y tiene que haber recibido un cobro médico que el Medi-Cal, Medicare, seguro médico privado o algún otro beneficio no pagará.			
¿Cuáles son los ingresos de 138% del Nivel de Pobreza Federal (FPL)?	Los ingresos están basados en el número de miembros de su familia. **El ingreso mensual en 2018 del 138% de FPL es de $1,3897 para una familia de una persona; $1,893 para dos; $2,390 para tres; $2,887 para cuatro; $3,384 para cinco; $3,881 para seis; $4,377para siete; $4,874 para ocho; $5,371 para nueve; $5,868 para diez.** Para familias con más de ocho personas, añada aproximadamente $497 por persona. En casos de mujeres embarazadas, se cuenta la mujer y él bebe o bebes que espera. Un trabajador del Condado determinará si su ingreso califica para estos programas y la cantidad que tendrá que pagar.			
¿Pueden recibir atención médica a bajo costo las personas que no son residentes del Condado de Los Ángeles?	**Sí, personas que no son residentes del Condado de Los Ángeles con ingreso menos del 350% del FPL (Nivel Federal de la Pobreza) podrían recibir un descuento.** *Solamente los residentes del Condado de Los Ángeles pueden obtener cuidado médico sin costo.*			

Para obtener más información sobre estos programas y donde aplicar, visite www.dhs.lacounty.gov - O vea el reverso de esta hoja para localidades del Condado de Los Angeles

~~EXHIBIT I~~

COUNTY OF LOS ANGELES DHCS LIST OF LOCAL PROGRAMS (SPANISH)

COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES

Información adicional acerca de los programas Sin Costo o A Bajo Costo en el Condado de Los Angeles	
Cómo aplicar para ATP	**ATP:** Los pacientes aplican para el ATP durante una cita de evaluación de financias en los hospitales o clínicas listadas abajo. La cantidad que tiene que pagar, si es que tiene que pagar, está basada en sus ingresos. La aplicación es para todo un año.
¿Cuáles son los pagos para el ATP?	ATP ahora cubre el cuidado de paciente externo e interno como parte del mismo acuerdo. El programa anterior de ORSA ahora es parte del ATP. Si tiene alguna pregunta acerca de este cambio, pregúntele a un trabajador de finanzas. • Pacientes con ingresos sobre el 138% del FPL pagan un costo bajo por sus servicios. • Pacientes pagan **una cantidad** por admisión (hospitalización), sin importar el número de días que este ingresado. • Pacientes solo pagan **una cantidad por mes** por cuidado de paciente externo, sin importar el número de visitas externas que tengan durante el mes. • Los pacientes que reciben Asistencia General (General Relief) reciben cuidado médico sin costo.
¿Puedo usar ATP para servicios no cubiertos por otros programas?	**Sí** – Usted puede usar el ATP para los servicios que no cubre el Medi-Cal, Medicare, o seguro médico privado. • ATP cubrirá el deducible de su seguro médico privado, pero no cubre el deducible de su Medicare o Parte del Costo de Medi-Cal.
¿Me podrían dar más tiempo para hacer pagos?	**Sí –** Usted recibe ATP o el Plan de Descuento de Pagos y no puede pagar la cantidad que debe dentro de 30 días, usted puede hacer arreglos para hacer pagos durante un periodo de tiempo más largo. El plazo de nuestro plan de pago extendido se basa en sus ingresos, recursos y número de miembros de su familia.
¿Tengo que aplicar para Medi-Cal antes de obtener un programa del Condado sin costo o a bajo costo?	**Sí** - Un trabajador del Condado determina que usted podrida ser elegible para Medi-Cal. Además, las madres que usen el Plan de Maternidad tendrán que aplicar para el Medi-Cal para su bebé. *Si usted no coopera plenamente con el proceso de inscripción de Medi-Cal, no podrá recibir ATP o el Plan de Maternidad.* **No** – Si usa el plan de Pago por Adelantado o el Plan de Maternidad solo para la madre, la madre no tendrá que aplicar para el Medi-Cal.
Cantidades de Pago Por Adelantado	$60 por cada una de las primeras 7 visitas prenatales, las demás visitas son sin costo; $60 por cada visita a los Centros de Salud Comprensiva (CHC) y Centros de Salud (HC); $80 por visitas a clínicas de hospitales del Condado. MLK Outpatient Center, & High Desert Regional HC $80 por visita de urgencia en todos los centros médicos; $140 por visita a sala de emergencia en hospitales $500 por cirugías en clínicas externas
¿Será mi situación migratoria afectada al utilizar estos programas?	Si usted recibe asistencia a través de los programas sin costo o a bajo costo del Condado, el Servicio de Inmigración y Naturalización (USCIS) de EE.UU. **NO** lo considerará como una carga pública.
¿Qué paso con Healthy Way LA (HWLA)?	El programa de Healthy Way LA se finalizó el 31 de Diciembre del 2013. El Medi-Cal ahora cubre aquellas personas que hubieran sido elegibles para el HWLA. Si usted tenía HWLA y no dispone de Medi-Cal, consulte con un trabajador del Condado.

PARA MAS INFORMACION Y DONDE SOLICITAR ATENCION MEDICA SIN COSTO O A BAJO COSTO EN EL CONDADO DE LOS ANGELES				
Hospitales	Harbor/UCLA Medical Center Patient Financial Services 1000 West Carson St. Bldg. 3-South Torrance 90509 (310) 222-3012	LAC+USC Medical Center 1100 N. State St. T-17 – Billing Inquiry Los Angeles 90033 (323) 409-6361	Olive View/UCLA Medical Center 14445 Olive View Dr. 2nd Floor, Room 2D142 Sylmar 91342 (747) 210-4154	Rancho Los Amigos National Rehabilitation Center 7601 E. Imperial Hwy. Bldg.602 Downey 90242 (562) 385-7320
Clínicas	Antelope Valley Health Center 335-B E. Ave. K-6 Lancaster 93535 (661) 471-4147 (661) 471-4000 Bellflower Health Center 10005 E. Flower St. Bellflower 90706 (562) 526-3000 Dollarhide Health Center 1108 N. Oleander Compton 90220 (310) 763-2244 El Monte Comp. Health Center 10953 Ramona Boulevard El Monte 91731 (626) 434-2500	Glendale Health Center 501 N. Glendale Ave. Glendale 91206 (818) 291-8900 H. Claude Hudson Comp. Health Center. 2829 South Grand Ave. Los Angeles 90007 (213) 699-7000 H.H. Humphrey Comp. Health Center 5850 So. Main St. Los Angeles 90003 (323) 897-6000 Harbor/UCLA Family Health Center 1403 West Lomita Blvd., 2nd Floor Harbor City, 90710 (310) 534-7600	Lake Los Angeles Clinic 16921 E. Avenue 0, Space G Lake Los Angeles 93535 (661) 471-4000 La Puente Health Center 15930 Central Ave. La Puente 91744 (626) 986-2900 Littlerock Community Clinic 8201 Pearblossom Hwy. Littlerock 93543 (661) 471-4000 Long Beach Comp. Health Center. 1333 Chestnut Ave. Long Beach 90813 (562) 735-2300	Mid Valley Comp. Health Center 7515 Van Nuys Blvd. Van Nuys 91405 (818) 627-3000 San Fernando Health Center 1212 Pico St. San Fernando 91340 (818) 627-4717 South Valley Health Center 38350 40th St. East Palmdale 93550 (661) 471-4000 Wilmington Health Center 1325 Broad Ave. Wilmington 90744 (310) 518-8800	Martin Luther King, Jr. Outpatient Center 1670 East 120th St. Los Angeles 90059 (424) 338-1817 High Desert Regional Health Center 335 East Ave I Lancaster 93536 (661) 471-4000 E. R. Roybal Comp. Health Center 245 S. Fetterly Ave. Los Angeles 90022 (323) 362-1010

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Exhibit I – County of Los Angeles DHCS List of Local Programs (English & Spanish)

Reviewed 11/18/21, 1/2022

- End -