St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

DISCOUNTED CARE POLICY	EXHIBIT B

APPLICATION FOR DISCOUNTED CARE

The Discounted Care program provides financial assistance through a reduction in your patient financial responsibility. Patients may also complete an application for the Charity Care program which offers a complete (100%) write-off of charges for medically necessary care to eligible patients.

Patient Information		
Name:	Phone Number:	
Date of birth:	SSN:	
Address:		
City:	State:	Zip Code:

Applicant (Guarantor) Information ☐ **If same, check box and proceed to question 1**			
Relationship to patient :			
Name:		Date of Birth:	
SSN:	Phone Number:		
Address:	City:	State:	Zip:

1. Are you covered Medi-cal, Medicare and/or any other insurance?	☐ YES	☐ NO
2. Would you like to apply or reapply for Medi-cal?	☐ YES	☐ NO
3. Are you eligible for any government programs?	☐ YES	☐ NO
4. Was your service related to a car accident or work accident?	☐ YES	☐ NO
5. If so, what is the name of the third party insurance?		
6. Are you employed?	☐ YES	☐ NO
7. If no, are you disabled?	☐ YES	☐ NO

Family Information: Please list information for yourself, your spouse/partner and dependents under the age of 21 living in your home below:

Name	Age	Relationship to patient

Total Family Size:

*If there are additional dependents, add them in the space provided on page 4 of this application.

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

DISCOUNTED CARE POLICY	EXHIBIT B

INCOME VERIFICATION

How are you paid? Answer the following income questions for patient and spouse if applicable. The income verification process requires proof of income documents. *Acceptable proof of income documents include:* most recent tax return, 2 most recent check stubs, a letter from employer stating earned wages, a perjury statement or proof of unemployment.

Type of Income	Amount	How often (Circle One)
Employment: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Employment: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Cash Income: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Cash Income: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Unemployment: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Unemployment: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Disability: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Disability: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Social Security: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Social Security: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Workers Comp: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Workers Comp: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Child Support: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Child Support: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Other Income:		Weekly/ Bi-weekly/ Monthly/ Other
Other Income:		Weekly/ Bi-weekly/ Monthly/ Other
Other Income:		Weekly/ Bi-weekly/ Monthly/ Other
Total Monthly Income:		

Patient Acknowledgement Statement

I certify that the information that I have provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance, I will contact/notify the facility. I understand that upon submission of this application, it will be screened for discounted care eligibility. I understand that if it is determined that I qualify to receive discounted care; I will be financially responsible for a portion of my care.

_____ _____

Patient/Guarantor Signature Date

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

DISCOUNTED CARE POLICY	EXHIBIT B

Self-Declaration of Income (Must be completed if you do not have proof of income)

Please complete the information below ***only if you have no other way to document*** your income. All of the boxes must be checked, and all questions answered. Failure to complete this information will result in a denial of your application for discounted care.

- ☐ I get paid in cash
- ☐ I do not receive pay checks/pay stubs.
- ☐ I cannot provide a letter from my employer.
  Explain why:_____
- ☐ I do not have access to my financial information.
  Explain why:_____

Patient Certification Statement

I certify that I have no other way to document my income and that all above information is accurate. I understand that this information is to be used to determine eligibility for St. Rose Hospital discounted care. I understand that St. Rose Hospital officials may verify information on this form.

_____ _____

Patient signature Date

Employee Certification Acknowledgement

I certify that I have asked the applicant for proof of all sources of income received by the household prior to using this form. I made an effort to secure all other possible sources of income documentation. The information reported on this form was provided solely by the applicant and reflects accurately the household income as reported to me by the applicant.

_____ _____

Employee Signature Date

St. Rose Hospital
An ALAMEDA HEALTH SYSTEM Affiliate

DISCOUNTED CARE POLICY	EXHIBIT B

Additional Dependent Information

Please use this space to document dependents that are not already recorded in the space provided on page 2.

Name	Age	Relationship to patient