Pipeline Health - Eligibility for Patient Financial Discount (Charity) Application & Instructions

INSTRUCTIONS

I. All items/question on the application form must be completed for the application to be processed.

II. Patient signature & date is required. If guarantor/ spouse provide information as well, all must sign.

III. The attached worksheet proof of all income and expenses and supporting documentation must be received within 150 days of the initial patient billing.

IV. This application requires patient financial data.

V. The completed application & required documentation to be submitted to the applicable address as follows:

Community Hospital Of Huntington Park, 2623 E. Slauson Ave., Huntington Park, CA 90255, Attn: Admissions Dept.

Coast Plaza Hospital, 13100 Studebaker Road, Norwalk, CA. 90650, Attn: Admissions Dept

East Los Angeles Doctor's Hospital, 4060 E. Whittier Blvd, Los Angeles, CA 90023, Attn: Admissions Dept.

Central Business Office, 12940 Telegraph Road Santa Fe Springs, CA 90670

Memorial Hospital Of Gardena, 145 West Redondo Beach Blvd., Gardena, CA 90247, Attn: Admissions Dept.

VI. Was a federal income tax return (Form 1040) filed by patient for the most recent calendar year?

Yes ☐ No ☐

If Yes, a copy of the IRS return including all schedules must be submitted and is attached.

Yes ☐ No ☐

If No, patient did not file a federal income tax return, the following items must be provided:

1. A statement explaining why patient did not file a federal tax return.
   Yes ☐ No ☐
2. Two (2) most recent pay stubs from patient & family members residing in same household.
   Yes ☐ No ☐
3. The last two (2) months' of any financial/ bank statements/accounts
   Yes ☐ No ☐ N/A ☐
4. If no patient income, documentation provided detailing how patient supports self/ /family.
   Yes ☐ No ☐ N/A ☐

VII. Does the patient currently have health insurance?

Yes ☐ No ☐

If yes, what insurance does the Patient have?

____

If insured patient has High Medical Costs, the following is required:

1. Proof of patient's annual out-of-pocket costs incurred at the hospital within the twelve (12) months immediately preceding discharge
   Yes ☐ No ☐
2. Patient's out-of-pocket medical expenses paid by you or your family within the twelve (12) months immediately preceding discharge.
   Yes ☐ No ☐

VIII. Patient Information:

1. Patient Name: ____________________________
2. Patient SSN (Acct. #): ______-______-_______
3. Patient Date of Birth_______________________
4. Patient Home Phone # _____________________
5. Patient Work Phone #______________________
6. Patient Address: _________________________
7. Treating Facility: _________________________
8. Date of Service: ___________________________

IX. Patient Family Household Information

1. Spouse Name_____________________________
2. Spouse SSN: ________-__________-________
3. Spouse Birth Date: ________________________
4. List same household family members below*:

Name	Age	Relationship

*If patient 18 years age or older, list patient's spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not. If the patient is under 18 years of age, list the patient's caretaker relatives, parent(s), and other children younger than 21 years of age.

X. Responsible Party/ Guarantor Information

1. Relationship to Patient: ________________________
2. Guarantor Name______________________________
3. Guarantor SSN: ______________________________
4. Guarantor DOB: ______________________________
5. Guarantor Phone: ____________________________
6. Guarantor Home Address:

   ____

   ____
7. Guarantor Employer Name & Address: (If self-employed, give name of business)

   ____

   ____

   ____
8. Position: _____________________________________
9. Work Contact (Name):_________________________
10. Work Phone: __________________________________

XI. Homeless Affidavit

1. Patient is currently homeless:

Yes ☐ No ☐

I, (Insert Signature)___________________________,
hereby certify that I am homeless, have no permanent address, no job, savings or assets, and no income other than potential donations from others.

XII. Insurance (Third Party Payer) Information

1. Patient has applied for Medi-Cal or any other income-based/means tested government-sponsored coverage in the last 12 months?

   Yes ☐ No ☐

2. If yes, is patient's application still pending?

   Yes ☐ No ☐

3. If a decision reached, was patient awarded assistance?

   Yes ☐ No ☐

4. If yes, what amount was awarded? ______________

5. If a decision was reached and assistance not awarded please explain why the patient was denied?

   ____
   ____
   ____
   ____

6. Is a third party responsible for the medical care you will receive or have received (e.g. a work-related injury or auto accident)?

   Yes ☐ No ☐

7. If yes, please provide the party responsible for covering the losses (e.g., insurance carrier, claim #, contact phone number, etc.)

   ____
   ____
   ____
   ____

XIII. Financial Worksheets

A. Current Income

Type	Patient/ Guarantor	Spouse
1. Gross Wages & Salary/Year (before deductions)		
2. (Self-Employment) Income:		
3. Social Security/ Unemployment/ Disability/ Other Public Assistance		
4. Alimony/ Child Support		
5. Real Estate Rentals & Leases		
6. Interest & Dividends		
7. All Other Sources (attach list)		
8. Total Income (add all lines above)		

B. Monetary Assets

Type	Patient/ Guarantor	Spouse
1. Checking Accounts		
2. Savings Accounts		
3. Certificates of Deposit		
4. Stocks and Bonds		
5. Other Bank Accounts & Investment		
6. Other monetary assets (attach list)		
7. Total Amounts (add lines 1-6 above		

C. Monthly Expenses

Type of Expense	$ Monthly Amount
Rent or House Payment and Maintenance	
Food/Household Supplies	
Utilities & Telephone	
Clothin	
Medical/Dental Payments	
Insurance	
School or Child Care	
Chilld/ Spousal Support	
Transportation & Auto)	
Insurance	
School or Child Care	
Child or Spousal Support	
Transportation and Automobile Expenses (Including Insurance, Fuel, and Repairs)	
Installment Payments	
Laundry and Cleaning Expenses	
Other Unusual or Extraordinary Expenses* *(*Detailed information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (list as needed).*	
Total Monthly Essential Living Expenses (add lines 1 – 12 above)	

XIV. Required section VII financial worksheet fields for monetary assets, income, and expenses are all complete:
Yes ☐ No ☐

XV. Guarantor Attestation

Patient declares under the penalty of perjury that all t information provided herein is true and correct to the best of his/her knowledge and further understands and agrees as follows:

- Providing false or misleading information, or the intentional omission of material information, will result in the denial of this application and could result in legal actions being taken against me/us.
- Patient authorizes Pipeline Health to verify any information listed in this application, including employment status and credit history, for the purpose of determining eligibility for patient discount.
- Patient fully understands that the Patient (Charity) Discount programs are a "Payor of Last Resort."
- Patient therefore hereby assign to Pipeline Health all benefits due from any liability action, personal injury claims, settlements, and all insurance benefits which may become payable, for illness/ injury for which Pipeline Health or its subsidiaries provided care.

____
Signature of Patient/Guarantor

____
Date

____
Signature of Spouse

____
Date