Kindred Hospitals

Discharge Notice &
Charity Care/Financial Assistance Application Form Instructions

This is an application for free care or reduced-price care at any Kindred Hospital location ("Hospital").

Note regarding terminology: "Charity Care" is used in this application to refer to the scenario where a patient or guarantor has no financial responsibility. "Financial Assistance" is used in this application to refer to the scenario where a patient or guarantor has some financial responsibility but at a discounted rate (*i.e.*, a discount payment).

California requires all hospitals to provide free care or reduced-price care to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance.

Financial Assistance and Charity Care are generally secondary to all other financial resources available to the patient, including the following: group or individual medical plans; Workers' Compensation; Medicare; Medi-Cal or medical assistance programs; other state, Federal, or military programs; any other third-party coverage (e.g. auto accidents or personal injuries); or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.

In those situations where appropriate primary payment sources are not available, for medically necessary hospital care received on or after Jan 1, 2022, Hospital will consider patients for Financial Assistance and Charity Care under Hospital's Charity Care and Financial Assistance Policy, when third-party coverage, if any, has been exhausted, based on the following criteria:

Income as a Percentage of Federal Poverty Level	Percentage Discount	Category
Less than or equal to 200 percent	100 percent	Charity Care
201-300 percent	75 percent	Financial Assistance
301-400 percent	50 percent	

Charity Care: The full amount of patient or guarantor responsibility for hospital charges will be determined to be Charity Care for a patient or their guarantor whose income is at or below 200% of the current federal poverty level, adjusted for family size. *Kindred Hospital will not consider the value of assets to reduce Charity Care discounts for individuals in this category*.

Financial Assistance:

- Seventy-five percent of patient or guarantor responsibility for hospital charges will be determined to be Charity Care for a patient or their guarantor whose income is between 201% and 300% of the current federal poverty level, adjusted for family size. *Kindred Hospital will not consider the value of assets to reduce Financial Assistance discounts for individuals in this category.*

- Fifty percent of uncovered hospital charges will be determined to be Charity Care for a patient or their guarantor whose income is between 301% and 400% of the current

federal poverty level, adjusted for family size. *Kindred Hospital will not consider the value of assets to reduce Financial Assistance discounts for individuals in this category.*

Catastrophic Charity: The Hospital may write off Charity Care amounts for patients with family income in excess of 400 percent of the Federal Poverty Level when circumstance indicates severe financial hardship or personal loss.

The patient's or the patient's guarantor's financial obligation which remains after the application of any Charity Care or Financial Assistance schedule shall be payable as negotiated between the Hospital and the responsible party. The responsible party's account shall not be turned over to a collection agency unless payments are missed or there is some period of inactivity on the account, and there is no satisfactory contact with the patient.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by ***Kindred Hospital*** depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: Central Admissions Department which can be contacted at **(714) 261-9176, Option #2** You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- □ **Provide us information about your family**
  Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- □ **Provide us information about your family's gross monthly income (income before taxes and deductions)**
- □ **Provide documentation for family income**
- □ **Attach additional information if needed**
- □ **Sign and date the form**

Note: **You do not have to provide a Social Security number to apply for financial assistance**. If you provide us with your Social Security number, it will help speed up the processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail or fax completed application with all documentation to:
Kindred Hospital Los Angeles
5525 W. Slauson Avenue
Los Angeles, CA 90056
Attention Patient Relations Representative
Fax (310) 410-2892
Be sure to keep a copy for yourself.

To submit your completed application in person: a Patient Relations Representative at any Kindred Hospital location

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly!
You may receive bills until we receive your information.

Kindred Hospital

Charity Care/Financial Assistance Application Form – confidential

Please fill out all the information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION
Select all that apply: Are you applying for Charity Care (*i.e.*, free care)? □ **Yes** □ **No** Are you applying for Financial Assistance (*i.e.*, reduced-price care)? □ **Yes** □ **No**
Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*
Has the patient applied for Medi-Cal? □ **Yes** □ **No**
Does the patient receive state public services such as EBT-SNAP, or WIC? □ **Yes** □ **No**
Is the patient currently homeless? □ **Yes** □ **No**
Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No**

PLEASE NOTE
• For documentation of income, we only request recent paystubs or income tax returns. We accept, but do not require, other forms of documentation of income. • Patients applying only for Financial Assistance may receive less financial assistance than what may be available to them under the Charity Care program. • We cannot guarantee that you will qualify for financial assistance, even if you apply. • Once you send in your application, we may check all the information and may ask for additional information or proof of income. • Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION			
Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify _____)	Birth Date		Patient Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
Mailing Address _____ _ _____ _ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____

Employment status of person responsible for paying bill
□ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed:_____)
□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:
- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain_____)*

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INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.

Proof of income means:

- Current pay stubs (within *3 months*); or
- Last year's income tax return, including schedules if applicable.

You may, <u>but are not required to</u>, provide additional proof of income beyond current pay stubs and last year's income tax return.

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (*child support, loans, medications, other*)

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that ***Kindred Hospital*** may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of Charity Care or Financial Assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date