Help Paying Your Bill

Dameron Hospital Association – Financial Assistance Application (Charity Care and Discounted Payment)

Financial Assistance Programs

Dameron Hospital ("the Hospital") recognizes that many of the patients it serves may be unable to access quality health care services without financial assistance. The Hospital offers two programs: Charity Care, which is free care, and Discounted Payment, which is care at a reduced price. This is a single application for both programs.

If you apply only for the Discounted Payment Program, you may receive less financial assistance than may be available to you under the Charity Care Program. We encourage you to apply for both programs using this application.

Who Is Eligible

- Charity Care (free care): patients whose family income is below 150 percent of the federal poverty level.
- Discounted Payment (reduced price): patients whose family income does not exceed 400 percent of the federal poverty level and who are uninsured or have high medical costs.

Eligibility is based on your income and family size. The Hospital does not consider your monetary assets, savings, or bank accounts.

You may apply at any time. There is no deadline to apply, and the Hospital will not deny your application because of when it was submitted. You may apply even after your account has been sent to a collection agency or after a court judgment.

Income Documents – You Only Need One

To show your income, provide only ONE of the following, whichever you choose:

- **Recent pay stubs** – pay stubs dated within 6 months before or after the date you were first billed (or, if you are applying before service, within 6 months of when you submit this application); **OR**
- **Recent income tax returns** – tax returns that show your income for the year in which you were first billed, or for the 12 months before you were first billed.

You do not need to explain why you are providing one type of document instead of the other. The Hospital may accept other income documents if you choose to offer them, but the Hospital will not require any other documents to show your income. You will not be asked for bank statements, savings information, or asset information. If you cannot provide income documents, the Hospital may still find you eligible based on other available information.

Information you provide on or with this application will be used only to determine your eligibility for financial assistance. It will not be used for debt collection.

How to Submit This Application

Return the completed application and your income document by mail or in person to: Patient Accounting Department, Dameron Hospital Association, 525 West Acacia Street, Stockton, CA 95203. Phone: (209) 461-3147, Monday through Friday, 7:00 a.m. to 3:30 p.m.

Free help completing this application is available. Call (209) 461-3147 or visit the Patient Accounting Department. This application, the Charity Care/Discounted Payment Policy, and a plain language summary are available free of charge at all registration points, including the Emergency Department, the billing office, and the admissions office, and online at www.dameronhospital.org/patients-visitors/billing-information/financial-assistance/. All documents are also available in Spanish.

What Happens Next

The Hospital will review your application and notify you of its decision in writing, including the reason for the decision. If you qualify for a discount, you will receive a billing statement showing the amount you owe and how it was determined. If you already paid more than the amount you owe, the Hospital will refund the difference, with interest, within 30 days (amounts under $5.00 excepted). Interest-free extended payment plans are available. While your application is pending, collection activity on your account is suspended.

Emergency Physician Services

An emergency physician who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. Please contact the emergency physician’s billing office directly for information about their financial assistance programs.

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 State of California’s Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

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 888-804-3536 or go to healthconsumer.org for more information.

DAMERON HOSPITAL

Financial Assistance Application

Statement of Financial Condition – Please complete both pages

Your name: _____

Spouse or domestic partner name (if any): _____

Address: _____

City / State / ZIP: _____

Phone: _____

Social Security number (optional): _____

A. Family Members

List the members of your family. For adults, family includes your spouse or domestic partner and dependent children under 21 (or any age if disabled), whether living at home or not. For patients under 18, family includes a parent, caretaker relatives, and their other dependent children under 21 (or any age if disabled).

Name: _____ Age: _____ Relationship: _____

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Name: _____ Age: _____ Relationship: _____

B. Employment

Your employer and position: _____

Spouse/partner employer and position: _____

C. Monthly Income

Gross pay (wages, salary, commissions, tips): You $_____ Spouse/Partner $_____

Income from operating a business: You $_____ Spouse/Partner $_____

Other income (interest, rental, Social Security, pension/retirement, alimony or support, other): You $_____ Spouse/Partner $_____

TOTAL MONTHLY INCOME: $_____

D. Monthly Expenses (Optional)

This section is optional. It is used only if you request an extended payment plan, so the Hospital can take your essential living expenses into account. It is not required to determine your eligibility.

Rent or house payment $_____ Utilities $_____ Food $_____
Child/spousal support $_____

Insurance $_____ Transportation $_____ Medical/dental $_____
Other $_____

TOTAL MONTHLY EXPENSES: $_____

Signature

I declare that the information provided on this application is true and correct to the best of my knowledge. I authorize Dameron Hospital Association to verify my employment status for the purpose of determining my eligibility for financial assistance, as permitted by law.

_____
_____
Date Signature of Patient or Guarantor