VENTURA COUNTY
HEALTH CARE AGENCY

Setting the Standard in Health Care Excellence

Ventura County Health Care Agency (HCA) Hospital Charity Care Program Application

Applies to:	Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) hospital billed services
Policy Reference:	110.030 – Charity Care Policy
Effective Date:	05/25/2026

The Ventura County Health Care Agency (HCA) is committed to providing the highest quality healthcare and emergency services to members of our diverse community. Our mission is to provide excellent comprehensive, cost-effective, compassionate healthcare throughout Ventura County.

At the HCA, we strive to make health care available to everyone in our community, regardless of their ability to pay. Our programs include a Charity Care Program for patients at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), Eastman Physical Therapy, and clinics licensed under VCMC for medically necessary procedures. The Charity Care Program has one discount level based on individual or family income is less than 100% of the Federal Poverty Level.

You can request financial assistance if your household income is at or below 400% of the Federal Poverty Level (FPL). *(Please note that for patients in our Federally Qualified Health Centers (FQHC's), there is a separate application for our Sliding Fee Discount Program).*

PROGRAM AVAILABILITY LOCATIONS MARKED WITH •

Program Number	% of the Federal Poverty Level	Charity Care Program at non-FQHC Clinics	Charity Care Program at VCMC & SPH Hospitals
1	0% to 100%	•	•
2	100.01% to 138%	•	•
3	138.01% to 150%	•	•
4	150.01% to 200%	•	•
5	200.01% to 400%	•	•
6	greater than 400%	NOT AVAILABLE	NOT AVAILABLE

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PURPOSE OF THIS APPLICATION

The Ventura County Health Care Agency (HCA) offers a Charity Care Program to assist patients who are unable to pay the full cost of medically necessary services provided at Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH), Eastman Physical Therapy, and clinics licensed under VCMC.

This application does not apply to services provided in Federally Qualified Health Centers (FQHCs), there is a separate application for our Sliding Fee Discount Program.

Submitting this application allows HCA to review your eligibility for:

- **Charity Care**, if the review determines your expected payment would be $0, or
- The **Discount Payment Program**

WHAT IS CHARITY CARE?

HCA Charity Care provides **free hospital care**.

- If approved, your expected payment is **$0** for eligible hospital services
- Eligibility is based on **household income** and **insurance status or high medical costs**
- Applying does **not delay or affect medically necessary care**
- You may apply **before or after** you receive care

WHO MAY QUALIFY

You may qualify for Hospital Charity Care if **all** of the following apply:

- You do not have health insurance (self pay), or
- You have insurance but have high medical costs; and
- Your household income is at or below 100% of the Federal Poverty Level (FPL)
- Immigration or citizenship status is not required to apply.

- You consent to the use of presumptive eligibility for the consideration of Charity Care

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Medical Record / Account Number (if known): _____

Address: _____

City / State / ZIP: _____

Phone: _____ Email (optional): _____

Responsible Party (If Different from Patient)

Name: _____

Relationship to Patient: _____

Address: _____

City / State / ZIP: _____

Phone: _____ Email (optional): _____

HOUSEHOLD INFORMATION

Please list all members of your household.

Family & Household Members	
First and Last Name	Relationship

INCOME INFORMATION

Please provide your total household income.

You may submit **one** of the following (no other documentation is required):

- Recent pay stubs are within the last 6 month period before or after the patient was first billed or for preservices, when application is submitted
- A recent federal income tax return . Recent tax returns for the last year in which the patient was first billed or 12 months prior to when the patient was first billed.
- Benefit letter (Social Security, disability, etc.)

Household income amount: $_____ per ☐ month ☐ year

Important: HCA does **not** consider bank accounts, property, savings, or other assets when determining eligibility.

If you have no income, please explain: _____

_____

INSURANCE INFORMATION (IF APPLICABLE)

☐ I do not have health insurance.

☐ I have health insurance:

- Insurance name: _____
- Member ID (if known): _____

Applying for insurance (such as Medi-Cal or Covered California) **does not prevent** you from qualifying for the Discount Payment Program.

HIGH MEDICAL COSTS (IF APPLICABLE)

If you are insured or underinsured and believe you have high medical costs, please check the box below:

☐ I have out-of-pocket medical costs that exceed 10% of my household income. Please check all that apply:

☐ Copays / Deductibles / Coinsurance

☐ Other out-of-pocket hospital costs

(Documentation of medical expenses may be requested if needed to complete the review.)

(Optional) You may attach bills or explain here: _____

_____

HEALTH COVERAGE SCREENING

HCA can help you apply for programs such as Medi-Cal or Covered California.

Applying for health coverage:

- Does **not** delay your Charity Care decision, and
- Does **not** delay medically necessary care.

AUTHORIZATION AND ACKNOWLEDGEMENT

Please read and sign below.

I certify that the information provided in this application is true and correct to the best of my knowledge. I understand that:

- Charity Care decisions are based on income and applicable law
- Submitting this application does **not** guarantee approval
- If approved, the type of assistance (Discount Payment Program or Charity Care) will be determined using standardized criteria
- HCA may contact me if more information is needed
- Providing false information may result in denial of assistance

I authorize HCA to verify the information provided **only as permitted by law**.

Applicant Signature: _____

Date: _____

HOW TO SUBMIT THIS APPLICATION

Please return this application with required income documentation by:

- Mail or In Person:
    - 5851 Thille Street, Ventura, CA 93003
- Email: VCHCA.PatientAssistance@venturacounty.gov

If you need help completing this application or need language assistance, please contact:

Ventura County Health Care Agency – Patient Financial Services

Phone: (805) 648 - 9553

Email: VCHCA.PatientAssistance@ventura.org

Website: https://hca.venturacounty.gov/help-paying-your-bill/

Free language assistance and interpreter services are available upon request.

If you disagree with the determination, you may request a review.