Financial Assistance Program

APPENDIX B

Jewish Home & Rehab Center
FINANCIAL ASSISTANCE PROGRAM APPLICATION

Date:

Patient Name
Patient Address
City, State, Zip

Patient Name:
Patient Account:
Date of Service:

Thank you for choosing Jewish Home & Rehab Center (JHRC) for your healthcare needs. We are dedicated to enhancing the health of our community through compassionate and excellent care.

You may be eligible for financial assistance to help with your hospital bill at JHRC. Please note, this assistance does not cover physician bills.

Enclosed is a financial assistance application. Complete the entire form, include all required documentation, and ensure it is signed and dated to begin the review process.

Submit the completed application and documents to Patient Financial Services in person at the main admitting area of the hospital, or by mail to:

Jewish Home & Rehab Center
302 Silver Avenue San Francisco CA 94112
Attn: Patient Financial Services

Financial Assistance Program

You will receive a Determination of Eligibility for Financial Assistance letter within thirty (30) days of our receipt of your completed application and supporting documents. Please note that completing this application does not guarantee eligibility for financial assistance or any other

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program. Financial assistance is considered only after all potential payment sources (e.g., health insurance, Medicare, Medi-Cal, liability insurance) have been exhausted. Failure to provide the requested documents may result in the denial of your application.

Assistance with Bill Payment

Free consumer advocacy organizations, such as the Health Consumer Alliance, can help you understand the billing and payment process. For assistance, call 888-804-3536 or visit www.healthconsumer.org.

If you need help completing the application, please visit the Patient Financial Services office or call 415-469-2262, Monday through Friday, 9:00 AM to 5:00 PM. A representative will assist you.

For more information about the Financial Assistance Program, please visit our website at: https://sfcjl.org/about-charitable.htm.

_____

(Signature)

_____

(Printed name of financial counselor)
Financial Counselor

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Financial Assistance Application Form Instructions

Jewish Home & Rehab Center offers Financial Assistance, for qualified patients and residents (low-income uninsured patients and residents and low-income insured patients and residents with high medical costs that meet the program eligibility requirements) using the most recent Federal Poverty Level Guidelines.

The following qualifications must be met:

Gross family income levels must be at or below 200% of the Federal Poverty Guidelines for Charity Care, or between 201% - 400% Discounted Payment Program.

All applicable funding sources must be complied with, and a determination made based on full cooperation. These funding options include Medi-Cal, Covered California, California Victim Compensation Program, etc. Applications denied for lack of cooperation will not be considered for financial assistance. Applicants must complete and return the attached Financial Assistance Application with all supporting documents listed below within 15 days of receipt.

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

- Provide us information about your family
- Provide us information about your family's gross monthly income (income before taxes and deductions)
- Provide documentation for family income
- Provide documentation for family assets
- Attach additional information if needed
- May have high medical expenses/cost
- Must provide verification of qualified liquid assets for Financial Assistance consideration
- A completed and signed and dated Financial Assistance Application (included)

Proof of Income

Please provide the following:

☐ Copy of signed federal income tax return(s) for the current year or previous year

☐ Copy of bank statements for all bank accounts for the last three (3) months for **both** applicant & co-applicant

☐ Copy of three (3) most recent pay stubs for **both** applicant & co-applicant

☐ Copy of current year or previous year's W-2 or 1099 earnings statements for **both** applicant and co-applicant

☐ Copy of social security allotment letter and/or other proof of income **(see written documentation of all forms of income section)**

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☐ Written documentation of all forms of income (i.e., trust funds, stock dividends, child support, alimony, social security, public assistance, food stamps, disability, rental property, investment income, etc.)

☐ **If unemployed,** please provide a copy of your wage report/unemployment statement showing denial or eligibility for both applicant & co-applicant. If applicable, include copy of denial letter from Medi-Cal.

Written documentation of all forms of income

I.e., trust funds, stock dividends, child support, alimony, social security, public assistance, food stamps, disability, rental property, investment Income, other.

If you do not have any monthly income or there has been a recent change in your financial situation, you **must** provide a statement or letter explaining your circumstances. If someone else is supporting you, they must sign the support statement in the Additional Financial Documentation section of the application.
Note: Bank statements will not be accepted as proof of income

Identification

Please provide two forms of identification (i.e., driver's license, photo ID, utility bill, social security card, birth certificate, passport, etc.).
Send completed application and documentation to:

Jewish Home & Rehab Center
Attention: Patient Financial Service
302 Silver Avenue San Francisco, CA 94112
Or fax: (415) 477-2096

Please provide all the information to avoid delays in processing your application or it may be denied. Please note that if financial assistance is granted, it will only cover your medical bills from our facility. It will not apply to the bills for other medical providers, hospitals, or physicians unless they specifically agree to accept it.

NOTE: PLEASE CONTACT YOUR OTHER MEDICAL PROVIDERS DIRECTLY TO INQUIRE ABOUT ASSISTANCE OPTIONS.

When applying for financial assistance, you are giving consent for us to make necessary inquiries to confirm financial obligations or references. If you have any questions, please contact the Patient and Resident Financial Services Department at our voicemail line (415) 469-2262 or email BusinessOffice@sfcjl.org or you may visit https://sfcjl.org/about-charitable.htm.

The Patient and Resident Financial Services Department will notify you with the results in writing withing 30 days of receipt.

For more information regarding Federal Poverty Guidelines, Medi-Cal, Covered California, or CMS visit:
Federal Poverty Guidelines https://www.federalregister.gov
Covered California https://www.coveredca.com
Medi-Cal http://www.dhcs.ca.gov/Pages/default.aspx

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Application for Financial Assistance

Applicant Information:

Patient/Resident Name:	Spouse Name (If applicable)
Admission ID#: Medical Record#: Account #:	

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner

Address:	
Home Phone: Cell Phone:	Spouse Phone:
Date of Birth (Patient/Resident):	Date of Birth (Spouse):
Employer: ☐ Full Time ☐ Self ☐ Part Time ☐ Retired ☐ Seasonal	Employer: ☐ Full Time ☐ Self ☐ Part Time ☐ Retired ☐ Seasonal
Occupation:	Occupation:

Household Details: (Supporting documentation required. To list additional income, use the back of this application).

Member Name	**Age**	**Relationship**	**Monthly Income Sources**	**Annual Gross Income**
				$
				$
				$
				$
				$

Total Family Size: _____ Total Dependents:_____ Total Household Income: $

Screening Information:

- **Do you currently have health Insurance? (Y/N)_____If yes, please provide insurance information below:**
- Insurance Name: _____ Policy # _____
- Group Name/Number: _____
- Have you had health insurance that has been terminated in the past 3 months? (Y/N)____ if yes,

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complete the following:

- What type of insurance? (i.e., Medi-Cal, BCBS, United, HealthNet, Tricare, etc. Reason for insurance termination? _____
- Did you apply for cobra insurance coverage? (Y/N)_____ If so, when?

_____

- Former Employee Name:

_____

- Are you being treated for injuries covered by Workers Compensation? (Y/N) _____if yes, please provide the Name of Work Comp Carrier: _____ Adjusters Name:

_____

Adjusters Phone Number:_____ Injury date:_____ Claim Number:_____

- Are you being treated for injuries covered by Third Party Liability such as an Auto Insurance Company? (Y/N)____if yes, please provide the following information: Name of Auto Insurance or Attorney:_____Auto Insurance or Attorney Phone Number:_____Injury date:_____Claim/ Number:_____
- Are you active duty or retired military? (Y/N)_____ If so, are you eligible for VA Benefits? (Y/N)_____
- Have you applied for Medi-Cal or Disability? (Y/N) _____if yes, When? _____ Where?_____Caseworker:_____
- Has your household or income status changed since you last applied? (Y/N)_____
- Were you a victim of a crime? (Y/N)_____If yes, please provide the following information: Date of injury?_____ Name of Case Worker:_____CW Phone #:_____Case Number: _____
- Medi-Cal Notice of Action if applicable: (Y/N)_____
- If you have any other special circumstances which you would like us to consider when reviewing you application, please explain below or attach a detailed letter: _____

Patient/Resident/Applicant Name:	**Co-Applicant Name:**
Monthly Expenses:	**Assets:**
Rent/ Mortgage $	Checking Account (s) $
Utilities $	Saving Account (s) $
Food $	Other Cash Assets $
Cell Phone $	Credit Cards (Available Credit) $
Auto Loan $	Monthly Gross Income: $
Auto Insurance $	Employment Income $
Loans $	Spouse Income $
Child Support $	Retirement Income $
Credit Cards $	Government Benefits $

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Other $	Other $
Total Expenses $	**Total Income $**

Patient/Resident/Applicant Certification:

I,_____, CERTIFY the information I have provided is true and accurate to the best of my knowledge. I understand that if I do not cooperate with Jewish Home & Rehab Center in supplying ANY additional requested information, my application may be denied for possible financial assistance. I understand that the information which I submit is subject to verification by the FACILITY, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I understand that this application pertains to the facility charges and not physician's charges. I understand that if any information I have given proves to be untrue, I will be held responsible for the full amount of any medical services received from Jewish Home & Rehab Center. I am also aware that I am only applying for the account specified above, and that my financial status will have to be reevaluated and may require a new application for any/all future services deemed as medically necessary I receive at Jewish Home & Rehab Center.

_____ _____

Applicant signature **Date**

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Additional Financial Documentation

(Only complete if applicable)

Patient/Resident Name:_____ Date:_____

☐ **Support Statement:**

My signature will certify that I, _____, do provide all necessary essentials for living for the patient/resident's behalf, and have done so for a period of _____ years/months.

_____ _____ _____

Signature of Patient/Resident's Supporter Relationship to Patient/Resident Date

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☐ **Homeless Affidavit:**

I,_____ (PRINT NAME) hereby certify that I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

Signature _____Date_____

☐**No Changes to Financial Status since Previous Application for Assistance**

I,_____ (PRINT NAME) hereby certify there have been no changes to my (nor my households) financial status since my previous application for financial assistance from Jewish Home & Rehab Center which was completed on_____. Please select of the following options:

☐ I am still being supported by another. They provide all necessary essentials for living for my behalf and have done so for a period of _____years/months.

☐ I am still homeless. I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

☐ There are no changes to my (or my spouse's) income or household size since my previous application.

Signature:_____ Date:_____

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For Office Use Only

Eligibility Determination

Charity Program ☐ Eligible ☐ Ineligible

Discount Program ☐ Eligible ☐ Ineligible

Denied Reasons:

- ☐ Non-compliance
- ☐ Insured by government or non-government payer
- ☐ Services were not received at Jewish Home & Rehab Center
- ☐ **Over 30 Days – Failed to provide requested verifications**
- ☐ Other (specify) _____
- ☐ Income over 400% FPL
- ☐ No high medical cost
- ☐ Services received are already discounted

_____

_____

Eligibility determination made by:

Print Name: _____

Signature: _____ Date: _____

Date sent to the patient/resident for final determination: _____ Patient Financial Services Staff completing this form

Initial: _____ cc: Copy sent to: _____

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DISPUTE OR APPEAL PROCESS FOR DENIED APPLICATION Determination - Appeals

If you have been determined ineligible for the Charity Care and Discount Payment programs and wish to appeal your denial for eligibility, you have 15 business days to appeal from the date of your eligibility determination. Please submit a copy of this completed application with your written statement below of the reason or your appeal request to:

Jewish Home & Rehab Center
Attention: Patient Financial Services
302 Silver Avenue San Francisco, CA 94112
Or fax: (415) 477-2096

Reason for dispute or appeal request:		
DISPUTE OR APPEAL DECISION **Decision**		**Reason for Dispute or Appeal**
Charity Program **Discount Program**	☐ **Eligible** ☐ **Eligible**	☐ **Ineligible** ☐ **Ineligible**
Decision made by:		
Print Name:		
Signature:		
Date:		

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Jewish Home & Rehab Center

Financial Assistance Appeal Form
Request for Re-Evaluation on Financial Assistance Denial

General Information Date:
Name of Patient:
Date of Birth:
Address: City, State, Zip Code:
Phone Number:

Guarantor Name (if different than patient):
Relationship:
Date of Birth:
Guarantor Address:
City, State, Zip Code:
Phone Number:

Please provide the reasons for your appeal of the Financial Assistance Denial. Your appeal letter must include supporting documents that demonstrate your inability to pay, which were not considered initially. Submit your appeal letter and supporting documents either by person or by mail to the following address:

Jewish Home & Rehab Center

302 Silver Avenue San Francisco, CA 94112

Attn: Patient and Resident Financial Services Department

You will receive a determination on your appeal within thirty (30) days of receipt of your complete submission.

Assistance with Bill Payment

Free consumer advocacy organizations, such as the Health Consumer Alliance, can help you understand the billing and payment process. For more information, call 888-804-3536 or visit www.healthconsumer.org.

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If you have any questions, please contact one of our Patient Financial Services representatives at (415) 469-2262.

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state initiative that reviews hospital decisions regarding financial assistance eligibility. If you believe you were wrongly denied financial assistance, you may file a complaint at www.HospitalComplaintProgram.hcai.ca.gov.