Community Hospital
of the Monterey Peninsula
Montage Health

APPLICATION FOR SPONSORED CARE OR DISCOUNT PAYMENT PROGRAM

This is an application for the Sponsored Care and Discount Payment programs.

Please be sure to attach required documentation as indicated on the application.

This program is the payer of last resort and should only be accessed after all other means of payment have been exhausted. This means that you will be encouraged or, if needed, assisted in applying for government programs such as Medicare, Medi-Cal, or California Health Benefit Exchange. To be eligible your claim cannot be covered by any Third Party Liability (TPL) or Workers Compensation insurance. Enrollment Counselors are available at Community Hospital to help you through the application process for most government programs.

If you apply and are deemed eligible by Community Hospital for Sponsored Care or the Discount Payment Program, you will be notified of the discount amount for which you have been approved. This program does not cover fees and charges from other providers (including physicians) for which Community Hospital does not bill, nor does not cover transportation costs (i.e. ambulance).

If you have questions regarding the completion of your application please call us at any of these numbers:

For information **prior** to care or services contact the clinical department where you are seeking services.

For information **during** care contact Patient Access (831) 625-4910

For information **after** care contact Patient Business Services (831) 625-4922

Community Hospital of the Monterey Peninsula
Montage Health

APPLICATION TO DETERMINE SPONSORED CARE OR DISCOUNT PAYMENT PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if independent and age18 or older or an emancipated minor) in order to determine if the applicant is eligible for Community Hospital 's Sponsored Care or Discount Payment Program. The term "applicant" means the patient for whom Community Hospital provided or will provide medical services. Please type or print clearly.

A. APPLICANT INFORMATION

1. Name of applicant (Last, first, middle): _____
2. Any other name the applicant is known by: _____
3. Date of birth (Month, day, year): _____
4. Social Security number: _____
5. Residence address:

_____

Number and street (do not use P.O. Box) City State Zip

6. Mailing address (if different from residence):

_____

Number and street (do not use P.O. Box) City State Zip

7. Daytime phone number:_____ 8. Evening phone number: _____
9. What is your preferred language? _____
10. Type of service provided or requested: _____
11. The Sponsored Care and Discount Payment programs require submission of the following documentation:
    - Signed completed application form
    - Proof of income:
        - Copy of your federal tax return transcript of recent tax year. Must be obtained through the IRS website.
            - Log into WWW.IRS.GOV
            - Click on Get Your Tax Record
            - Scroll down to" Request Online"
            - Click on Get Transcript Online and follow instructions.

          Detailed instructions can be provided upon request.
        - Pay stubs from the past 3 months, for all members of the family
        - Copy of most recent W2 form (Sponsored Care Program only) for the following family members: spouse, domestic partner, dependent children, and parent if applicant is a minor.

B. PARENT/LEGAL GUARDIAN INFORMATION (Applicants age 18 or older or emancipated minors skip items 13 through 18)

12. Name(s) of parent or legal guardian:_____ Relationship: _____
13. Residence address:

_____
Number and street (do not use P.O. Box) City State Zip

14. Mailing address (if different from residence):

_____
Number and street (do not use P.O. Box) City State Zip

15. Daytime phone number:_____ 16. Evening phone number: _____

17. Message phone number: _____

C. HEALTH INSURANCE INFORMATION

18. Does the applicant have Medi-Cal? If yes, what is the applicant's Medi-Cal ID number?
19. Does the Applicant have other health insurance including but not limited to:
    - Third Party insurance coverage
    - Eligibility or active coverage with the California Health Benefit Exchange

_____ Initial here	I am applying for the hospital's Sponsored Care or Discount Payment Program as indicated above. I understand that failure to provide requested information by the due date will result in denial of my application.
_____ Initial here	I certify that I have read and understand the information on this application.
_____ Initial here	I certify that the information I have given on this form is true and correct.
_____ Initial here	I give my permission for Community Hospital of the Monterey Peninsula to contact any healthcare provider regarding my medical care and treatment.
_____ Initial here	I understand and agree that a credit report will be run on all Sponsored Care requests. Other verifications such as employment and property ownership searches may be conducted at the hospital's discretion.

Additional comments: _____

_____

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_____ _____
Applicant's signature Today's date