Heritage Oaks Hospital
Application for Discount or Charity
Solicitud de descuento o beneficencia

It is the policy of Heritage Oaks Hospital, in compliance with California State law AB774 (Hospital Fair Pricing Policies) to provide discounts from standard billed charges for all self pay and high medical cost patients as defined above. To determine if you are eligible for discount or charity, please complete the following information (the business office staff will assist in completion of the form if requested) **Please note:** If you are applying for discount payment only, you may receive less financial assistance than what may be available under charity care:

Es política de Heritage Oaks Hospital, según la ley estatal AB774 de California (Políticas de fijación de precios justos para hospitales), proporcionar descuentos en gastos estándares facturados para todos los pacientes que pagan por cuenta propia y pacientes con costos médicos elevados según se define a continuación. Para determinar si usted es elegible para un descuento o beneficencia, complete la siguiente información (el personal de la oficina comercial lo ayudará a completar el formulario si fuese necesario) ***Tenga en cuenta****: si solicita pago con descuento únicamente, es posible que reciba menos asistencia financiera que la que puede estar disponible bajo atención caritativa:*

When applying for a Discount, the facility may only require confirmation of income through either recent paystubs or income tax returns. To apply for Discount only, please complete Section 1. To apply for Charity Care, please complete both Section 1 and Section 2.

Al solicitar un descuento, es posible que el centro solo requiera confirmación de ingresos a través de talones de pago recientes o declaraciones de impuestos sobre la renta. Para solicitar el descuento únicamente, complete la Sección 1. Para solicitar Atención de caridad, complete la Sección 1 y la Sección 2.

Section 1 (For Discount and Charity Care):

Patient Name (*Nombre del paciente*): _____

Patient account # (*Número de cuenta del paciente*): _____

Guarantor Name (*Nombre del garante*): _____

Annual income (*Ingreso annual*): $_____

(Note: annual income must be supported by either a current pay stub or your most recent income tax return).
(*Nota: el ingreso anual debe estar acompañado de un recibo de sueldo o su declaración de impuesto sobre las rentas más reciente*).

Section 2 (For Charity Care ONLY):

Number of persons in family or household (*Cantidad de personas de la familia o en la casa*): _____

Out of pocket medical expenses during the previous 12 months (including an estimate of your out of pocket costs for this hospitalization) (*Gastos médicos en efectivo durante los 12 meses anteriores (incluido un estimado de sus costos en efectivo para esta hospitalización)*): _____

Total monetary assets (excluding retirement or deferred compensation plans) (*Total de activos monetarios (sin incluir los planes de retiro o de compensación diferida*)): $_____

For completion by business office staff only.

1. Annual income _____
2. Federal Poverty Level (FPL) for family size _____
3. Line 1 as a percent of line 2 _____
4. Maximum payable by Medicare or Medi-Cal for stay _____
5. Total monetary assets _____

Insured patients only:

6. Expected out of pocket cost for this stay _____
7. Total out of pocket expenses-previous 12 months _____
8. Line 6 plus line 7 as a percent of line 1 _____

Discount for self-pay patients to be applied to the stay based on the following grid:

Line 3 percent	**Required discount**	**Approved discount**
Greater than 400%	0%	
251% to 400%	Higher of Medicare or Medi-Cal payment for stay	
101% to 250%	50% of the higher of Medicare or Medi-Cal payment for stay	
Up to 100% and line 5 less than	100%	

$10,000		
Up to 100% and line 5 greater than $10,000	0%. Total payment may not exceed amount of line 5 greater than $10,000.	

Discount for insured patients to be applied to the stay based on the following grid:

Line 3 percent	Required discount	Approved discount
Greater than 400%	0%	
Less than 400% and line 8 is greater than or equal to 10%	Total payment received from insurance plus patient will not exceed 100% of the higher of Medicare or Medi-Cal payment	

Federal Poverty Guideline as of 01/12/24:

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$ 15,060	$18,810	$17,310
2	20,440	25,540	23,500
3	25,820	32,270	29,690
4	31,200	39,000	35,880
5	36,580	45,730	42,070
6	41,960	52,460	48,260
7	47,340	59,190	54,450
8	52,720	65,920	60,640
For each additional person, add	5,380	6,730	6,190