John C. Fremont Healthcare District

John C. Fremont Financial Aid

Thank you for choosing John C. Fremont Healthcare District. Please follow the instructions below to complete the financial aid application for consideration:

Instructions:

1. Complete this application attached by filling in the blanks.

2. Supply the documents supporting the income amounts you have listed. **The following documents are required:**
   - Letters of denial or approval for Medicaid, A Marketplace Health Plan (Obamacare), medical assistance, or any other benefit applied for.
   - 3 current pay stubs from all employers with year to date gross
   - Copy of your last year's income tax return
   - Copy of latest bank statement
   - Letters denying unemployment compensation (if applicable)
   - Written statements from employers or welfare agents (if applicable)

3. Sign your name and date the completed application.

4. If you have questions or need assistance in completing this application, please contact Patient Accounts Department at **844-288-2028.**

Exhibit A

JOHN C. FREMONT HEALTHCARE DISTRICT – Confidential Financial Statement (Application)

Patient Name_________________________	**DOS:** ___________________
Patient Number______________________	**Confidential Financial Statement (Application)**

RESPONSIBLE PARTY

Name		Marital Status	Social Security Number
Street Address, City, State, Zip		How long at this address	Home Phone
Employers Name and Address (If Unemployed –How Long)			Business Phone
Position / Title	Monthly income – Gross	Monthly income – Net	Length of current employment

SPOUSE

Name			Social Security Number
Employer Name and Address			Business Phone
Position / Title	Monthly income – Gross	Monthly income – Net	Length of current employment

DEPENDENTS

Name & Year of Birth of all persons in household	Total Number of Persons in Household____	Do Any Other Persons Contribute? If Yes, Amount: Yes/No _________ Amount ______________

INCOME PER MONTH & ASSETS

Dividends, Interest	$	**Child Support / Alimony**	$
Public Assistance / Food Stamps	$	Rental Income	$
Social Security	$	Grants	$
Unemployment Compensation	$	IRA	$
Workers' Compensation	$	Other	$
Savings	$		$

EXPENSES PER MONTH

Mortgage / Rent $	Balance: $	Medical / Dental	$
Own Home? (Yes/No)		Doctor – Name	
Food	$	Doctor – Name	$
Utilities:		Doctor – Name	$
Electric	$	Credit Cards:	$
Gas	$	Visa Limit	$
Water / Sewer	$	MasterCard Limit	$
Trash	$	Discover Limit	$
Phone	$	Other Limit	$
Cable	$	Installment Loans	$
Auto Payments	$	Child Support	$
Auto Expenses	$	Miscellaneous Expenses	$
Insurance:	$		$
Auto Premium	$		$
Life Insurance	$		$
Health Insurance	$		$

OFFICE USE ONLY Gross income_________________________ Net income___________________________ Total Expenses________________________ Total Net income(loss)__________________	To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing. ____ ____________________ ***PATIENT/GUARANTOR SIGNATURE*** ***DATE***

Exhibit A (Spanish)

JOHN C. FREMONT HEALTHCARE DISTRICT- Confidential Financial Statement (Application) in Spanish

Nombre del Paciente ______________________________	OFICINA __________________ DOS ____________________
Número del Paciente ______________________________	**DECLARACION CONFIDENCIAL DE ESTADO FINANCIERO**

PERSONA RESPONSABLE

Nombre	Estado Civil	Número de Seguro Social	
Dirección, ciudad, estado, código postal	¿Cuánto tiempo ha vivido en esta dirección?	Teléfono de su domicilio	
Nombre y dirección de su empleador (Si está desempleado, ¿por cuánto tiempo?)		Teléfono de su trabajo	
Empleo/Puesto	Ingreso mensual-Bruto	Ingreso mensual-Neto	Tiempo en su empleo actual

ESPOSA/ESPOSO

Nombre		Número de Seguro Social	
Nombre y dirección del empleador		Teléfono de su trabajo	
Empleo/Cargo	Ingreso mensual-Bruto	Ingreso mensual-Neto	Tiempo en su empleo actual

DEPENDIENTE

Nombre y año de nacimiento de todos los dependientes que viven en su casa	Número total de dependientes que viven en su casa:_______	¿Alguna otra persona contribuye? Si la respuesta es sí, ¿con qué cantidad? : Sí/No________ Cantidad _______________

INGRESO MENSUAL Y ACTIVOS

Dividendos, Intereses	$	**Manutencion para hijos menores/esposa**	$
Ayuda pública/Cupones de alimentos	$	Ingreso por alquileres	$
Seguro social	$	Acciones, bonos	$
Compensación por desempleo	$	Subvenciones (*grants*)	$
Compensación por accidente de trabajo	$	Cuenta de jubilación individual (*IRA*)	$
Ahorros	$	**Otros inmuebles, sin incluir a su vivienda**	$

GASTOS MENSUALES

Pagos de hipoteca/alquiler	Saldo $	Gastos médicos/dentales		$
¿Es propietario de su vivienda? (Sí/No) :				
Alimento	$	Doctor-Nombre		$
Servicios públicos:		Doctor-Nombre		$
Electricidad	$	Doctor-Nombre		$
Gas	$	Tarjetas de crédito::		$
Agua-Alcantarillado	$	Visa	Límite	$
Recolección de basura	$	Mastercard	Límite	$
Teléfono	$	Discover	Límite	$
Cable	$	Otras	Límite t	$
Pago de vehículos	$	Préstamos a plazo		$
Gasto de vehículos	$	Manutención para hijos menores		$
Seguro :	$	Gastos misceláneos		$
Prima de vehículos	$			$
Seguro de vida	$			$
Seguro médico	$			$

SOLO PARA USO DE LA OFICINA
Ingresos brutos ____________________
Ingresos netos _____________________
Total de gastos ____________________
Ingreso neto total (pérdida)__________

Hasta donde me es posible saber, la información arriba proporcionada es correcta. Autorizo al Hospital o a su representante, para que obtengan un reporte de crédito para la verificación de mi situación financiera.

_____________________________________ ______________________

FIRMA DEL PACIENTE/GARANTE *FECHA*

Exhibit B

JOHN C. FREMONT HEALTHCARE DISTRICT - Confidential Financial Assistance Statement Summary

Hosptal: ______________________________
Patient Name: ________________________ Patient Number: ________________
Total Charges: __________________ Date of Service: _________________________
__ Deceased __ Homeless Date of Assignment: (if applicable) _____________

Coverage

To provide consideration for financial assistance, it is necessary that all other payer resources have been exhausted. Please identify that the patient has been screened, and deemed ineligible for the following potential programs:

θ Medicaid/Medi-Cal θ Disability θ Supplemental Security Income
θ Insurance Coverage θ Third Party Liability θ CCS/CDIC
θ County Program θ Victims of Violent Crimes θ Workers' Compensation

If a partial payment has been made it is to be deducted from total discount recommended:
Amount paid: $__________________ by whom ______________________________________

Income/Expense Verification

Please identify that income and expense has been verified.

- ☐ Income Verified. Source: ____
- ☐ Absence of income attestation. Completed by ____
- ☐ Statements of assets. (Bank statement copies, etc.)
- ☐ Mortgage/Rent Statements.
- ☐ Other living expenses. (Copies of utilities bills, Auto, Insurance)
- ☐ Patient Signature.
- ☐ Patient NET WORTH $ ______________________________

Summary for Charity Care Consideration:

____
____
____
____-
____

Percentage of FPG: %	**Eligible for write- off: YES____ No ______**	**Recommendation Amount:**
Eligible for Charity Care	**θ Yes**	**θ No**
Eligible for Reduced Payment Rate:	**θ Yes**	**θ No**

Submitted by: (Print Name) (Signature) (Date)

Phone Number: ________________________________ **Supervisor Signature:** ______________________________

- ☐ Confidential Financial Statement
- ☐ Worksheet
- ☐ Supporting Documents
- ☐ Credit Bureau Report

☐ **Non-Statutory G/L Account # XXXX.XXXX**	☐ **Statutory G/L Account # XXXX.XXXX**
BOM/DPFS:____________________________**Date** _________	**DPFS Approval:**_______________________________**Date**__________

Denied θ **Yes** θ **No**
Reason ____ **DPFS Denied** ____________________________**Date**________

Exhibit C

John C. Fremont Healthcare District - Clinic Notification Form
Eligibility Determination for Charity Care

John C. Fremont Healthcare District has conducted an eligibility determination for charity care for:

Patient Name	Account Number	Date(s) of Service

The request for Charity Care was made by the patient or on behalf of the patient on ____________________. This Determination was completed on __________________.

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

	Your request for charity care has been approved for services rendered on (DATE). After applying the charity care reduction, the amount owed is $____________________.
	Your request for charity care is pending approval. However, the following information is required before any adjustment can be applied to your account:
	Your request for charity care has been denied because:

If you have any questions on this determination, please contact: