Financial Assistance Application Form Instructions

Please use this form to apply for charity care (no-cost) or discounted care at [*hospital or name]*. Anyone can apply for financial assistance for free, regardless of their immigration status.

California requires hospitals to provide financial assistance to patients who meet certain income limits. You may qualify for free care or reduced-price care based on your household size and income, even if you have health insurance or another type of health coverage. The income limits for our hospital are shown in this table. ***Note:*** You may still qualify for financial help, even if your income is higher than the amounts listed. If you have a medical bill you can't afford, please reach out to our staff.

Who Qualifies:

[insert hospital policy regarding eligibility and sliding scale FPL%] [link to FPL guidelines on hospital website].

	NO-COST CARE if gross yearly income is less than:	**DISCOUNTED CARE if gross yearly income is less than:**
Number in family/ household	[Insert Hospital Threshold] example, based on the current average of 250% of **Federal Poverty Level**	[Insert Hospital Threshold] or mandated minimum 400% of **Federal Poverty Level**
1 person	$39,125	$62,600
2 people	$52,875	$84,600
3 people	$66,625	$106,600
4 people	$80,375	$128,600
5 people	$94,125	$150,600
6 people	$107,875	$172,600

Gross yearly income means the amount of income before tax.

For households of more than 6, add $5,500 for each extra person.

To learn more about Federal Poverty Levels, visit https://aspe.hhs.gov/poverty-guidelines.

All information provided on this form will be kept confidential in accordance with California and federal law.

How to get help with this application:

If you have questions or need help completing this form, please contact us at:
[insert location and phone number and hours of the appropriate office or department.]
If you're still in the facility, ask a billing staff member for assistance. We're here to help everyone, including those who need disability accommodations or want help in another language.

Financial Assistance Application Form Instructions (*continued.*)

You can also contact a free consumer advocacy group like the ***Health Consumer Alliance*** at 1-888-804-3536 or healthconsumer.org. They can help you understand the billing and payments system, apply for assistance, and appeal or reapply if your application is denied.

How to submit your application:

You can submit the application by mail, phone, fax, online, email, or in person.
[Hospital Mailing Address]
[Phone #]
[Fax #]
[Email]
[Website URL] Scan the QR code with a mobile device to view the form online

Insert QR code here

Location to submit your completed application in person:
[*Department/office,*
[Address]
[Hours]
[Phone #]

Make sure to include the required documents and keep a copy for your records. *There is no deadline to apply but the sooner you submit your application, the sooner we can offer discounted or free care*.

We will write to tell you if you are eligible for financial assistance within 30 calendar days after we receive your application and income documents. If we decide that you are not eligible, we will explain your rights and how you can appeal or reapply.

On this form, family is defined as:

If the patient is age 18 years of age or over: family means the patient, their spouse or domestic partner, the patient's dependent children under 21 years of age or any age if disabled, and any other individual the patient claims as a tax dependent, whether or not living at home. A domestic partnership is a committed relationship between two adults who mutually care for each other; both must be at least 18 years old if of the same sex, or if of opposite sexes, both persons must be capable of consenting to the domestic partnership. "Disabled" has the meaning in Section 1614(a) of Part A of Title XVI of the Social Security Act.

If the patient is under 18 years of age or a dependent child up to 20 years of age: family means the patient, their parent(s) or other caretaker relative(s), and the parents' or caretaker relatives' other **dependent** children under 21 years of age, or any age if disabled.

[Hospital/system name/logo] **Confidential**

Financial Assistance / Charity Care Application Form

Please fill out as much information as possible. If it does not apply, write "NA."

Presumptive Eligibility

Does the patient receive public benefits such as CalWORKs, CalFresh, WIC, or SSI? ☐ *Yes* ☐ *No*
Does the patient receive any other public benefits? ☐ *Yes* ☐ *No*
Has the patient applied for Medi-Cal or currently have Medi-Cal? ☐ *Yes* ☐ *No*
Is the patient currently experiencing homelessness or lacks permanent housing? ☐ *Yes* ☐ *No*

Patient and Applicant Information

Patient:

_____ _____ _____ ___/___/____
First name Middle name Last name Date of birth

Person responsible for bill *(if different from the patient):*

_____ _____ _____ ___/___/____
First name Middle name Last name Date of birth

Address for Patient or Person responsible for bill *(if different from the patient):*

_____ _____ _____ _____
Street address City State Zip code

_____ (___)_____ (___)_____
Email Phone Alternative phone

Other Identification Details (*optional*)

This information is optional but providing it may help your application to be processed faster.

_____-_____-_____ _____ _____
Social security number* Hospital record number Driver's license or ID number

**A social security number is not required to apply for or receive financial assistance.*

Household Size

Enter the total number of people in the patient's family
See form instructions for definition of family.

Total
_____

Household Members

List all your family members. Include people who are also applying for financial assistance. If the bill was from childbirth, please list both mother and baby's information. If more than 5 other people are in your household, list them on a separate sheet.

Name	Date of Birth MM/DD/YY	Relationship to You
_____	___/____/___	_____
_____	___/____/___	_____
_____	___/____/___	_____
_____	___/____/___	_____
_____	___/____/___	_____

Household Income

Check ALL types of income that you and your family members receive:

- ☐ Employment Income/Wages
- ☐ Business Income/Rental Property
- ☐ Unemployment Benefits
- ☐ Workers Comp/Disability Income
- ☐ Income from Annuities
- ☐ Alimony/Child Support
- ☐ Income from Pension or Retirement
- ☐ Social Security
- ☐ Veterans Benefits
- ☐ Other Income

Enter the total gross monthly income for all family members. Gross income is the amount *before* taxes and other deductions

Total $_____

Proof of Income

To be considered for financial assistance, you must provide information on the income of the patient and their family. To prove income, the hospital may only ask the patient for recent pay stubs or income tax returns. If the patient doesn't have these, other types of proof may be accepted, but are not required. If the patient has no proof of income, please explain why.

Examples of proof of income you can provide include:

- A "W-2" withholding statement OR
- Current pay stubs (*2 pay periods*) OR
- Most recent income tax return OR
- Written, signed statements from employers or others OR
- Approval/denial of eligibility for Medi-Cal and/or public benefit program OR
- Approval/denial of eligibility for unemployment compensation.

If the patient has no income, please explain how they pay their bills or support themselves. You can write the explanation on the back of this application or attach a separate page.

Health Savings Accounts

☐ **Check the box if there is a Health Savings Account(s) that can be used for the patient's expenses**. *If you're not sure if you have a health savings account, please contact the hospital for help.*

Enter the balance in your Health Savings Account(s) — Total $_____

Healthcare Costs

Enter the total out-of-pocket expenses you and your family members* had at this hospital or to any other medical provider over the last 12-months. Include deposits, copays, co-insurance, share of cost payments, deductibles, and other payments for medical, dental, vision, hearing, pharmacy services, and medical equipment or supplies prescribed to you.

Total $ _____

Enter the total amount you and your family members currently owe to this hospital.

Total $ _____

Agreement

I understand that by submitting this financial assistance application, I am giving [Hospital/system Name]'s, permission to verify my information. This may include a credit check and/or other steps to determine if I qualify for financial assistance, such as charity care or discounted care. I understand that these inquiries should not affect my credit score.

I understand that giving false financial information may lead to my application being denied.

_____ _____

Name of person completing this form — Date

_____

Signature of person completing this form