Financial Assistance Application Form Instructions

This is an application for financial assistance at **Foothill Regional Medical Center.**

We have two types of financial assistance programs — **Charity Care** and **Discount Payment**
You may qualify for free care or discounted care based on your family size and income. To view our financial assistance policy, please go to **www.foothillregionalmedicalcenter.com**

What does financial assistance cover? If you are not eligible for a government program and meet certain low- and moderate- income requirements, you may qualify for our Financial Assistance Program. We provide financial assistance to help qualified patients pay for healthcare based on their financial need. This includes emergency, urgent, or medically necessary care. Patients who qualify get some or all of their costs covered regardless of whether they have healthcare coverage, or are uninsured, or are underinsured.

Physicians who practice at **Foothill Regional Medical Center** are not included in this policy. If you need assistance with the physician bill, you will need to contact the physician's private office and speak to the office staff.

If you have questions or need help completing this application: You may obtain help for any reason, including language assistance, by calling our **Patient Financial Services** at **562-293-3200,** Monday through Friday, 8 a.m. to 4:30 p.m. You may also visit the website above.

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

- Provide us with information about your family
- Provide recent pay stubs or Tax Return
- Sign and date the form

Mail completed application and supporting documents to:
Foothill Regional Medical Center, Attention: Patient Financial Services
9542 Artesia Blvd, Bellflower, CA 90706

You may also submit the application and supporting documents in person at the same address. We will notify you of the final determination of eligibility and appeal rights, if applicable, within 30 days of receiving a complete application and supporting documents. If your application is incomplete, you will receive a letter requesting the required documents to process your application. By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly.
You may continue to receive billing statements until we
receive your completed application and supporting documents.

Financial Assistance Application Form — *Confidential*

Please note we cannot guarantee that you will qualify for financial assistance, even if you apply.

RETURN COMPLETED FORM BY MAIL TO:

Foothill Regional Medical Center, Attention: Patient Financial Services
9542 Artesia Blvd, Bellflower, CA 90706

You *may also submit the application and supporting documents in person at the same address.*

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

Application Date:	**Service Date:**
Social Security #: (optional)	■ I do not have a Social Security #
Patient Name:	**Patient Birth date:**
Account #:	**Phone #:** ■ Home ■ Cell
Street Address, City, State & Zip:	
Is patient currently unhoused? Yes ■ No ■	

Please call our **Patient Financial Services** at **562-293-3200,** Monday through Friday, 8 a.m. to 4:30 p.m. for any questions about filling out this form.

Please check the type of financial assistance you are interested in applying for:

❑ Charity Care
❑ Discount Payment

Please note:

(1) The hospital may only request recent paystubs or income tax returns for documentation of income. The hospital may accept other forms of documentation of income but shall not require other forms.
(2) Patients may receive less financial assistance than what may be available to them under the charity care program.

QUESTIONNAIRE:

(1) Was the patient a resident of California at the time of service? Yes ❑ No ❑
(2) Were the medical services received related to a motor vehicle accident, 3rd party injury, or workers' compensation? ***If* yes, *what is the date of injury?*** _____ Yes ❑ No ❑
(3). Did the patient have any active health insurance at the time of service? Yes ❑ No ❑
(4). Was the patient an active Medi-Cal recipient at the time of service? ***If yes, please*** Yes ❑ No ❑

attach a copy of your health insurance or Medi-Cal card to this application.

INCOME & FAMILY HOUSEHOLD SIZE:

- For purposes of determining eligibility, a patient's family is defined as a patient, 18 years or older, any domestic partner, dependent children of any age; or a patient under the age of 18, parents, caretaker relatives and other children under 21 who are the children or the responsibility of the caretaker relative. Family accounts for the inclusion of parents when the patient is a dependent child who is not a minor.

Family Member's Name	Birthdate	Relationship to patient	Income Source or Employer Name	Income for 3 months from Date of Service	Income for 12 months from Date of Service
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$

- **Proof of Income from all sources MUST be supplied with this application (e.g., 3 months of pay stubs from service date, most recent tax return (IRS Form 1040), etc.).**
- **If you report $0 income,** please provide a notarized letter of how you (or the patient) are surviving financially, including who provides food, shelter, transportation, etc., and how long you have been without income.

CURRENT EXPENSES (Past 12 months from Date of Service)
We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Medical Expenses** (hospital, doctor, dental, vision, prescriptions, etc.)	$	Health Insurance Premiums** (medical, dental, vision)	$

****Please provide all receipts/Explanation of Benefits noted above whether paid or unpaid.**

ADDITIONAL INFORMATION

Please attach an additional page if there is information about your current financial situation that you would like us to know, such as financial hardship, excessive medical expenses, or seasonal or temporary income.

PATIENT AGREEMENT

I affirm that the above information is true and correct to the best of my knowledge. I understand that if the information I provide is determined to be false, financial assistance may be denied, and I may be responsible to pay for services provided.

Applicant's Signature Date