ALAMEDA COUNTY MEDICAL CENTER

Highland Campus • Fairmont Campus
John George Psychiatric Pavilion • Ambulatory Healthcare Services

ACCOUNT NO:

MEDICAL RECORD NO:

PATIENT NAME:

DATE OF BIRTH:

UNIT: DATE:

CHARITY CARE / DISCOUNT POLICY PROGRAMS

☐ Eastmont ☐ Hayward ☐ Fairmont
☐ Highland ☐ Newark

CHARITY CARE / DISCOUNT POLICY BUDGET

	Income Source:	Amount	Income Equations
A. Self	_____	$_____	
B. Spouse / Parent	_____	$_____	Weekly _____ X 4.33 = $_____
C. Other (Specify)	_____	$_____	
	_____	$_____	Bi-Wkly _____ X 2.167 = $_____
	_____	$_____	
	No. Children		Semi-Mo _____ X 2 = $_____
D. Family Size	_____ Under 21 _____		

E. **TOTAL GROSS MONTHLY INCOME** $_____

Enrollment Period:
From _____ **to** _____

F. Use D and E to determine Percent of Charity Care Payment

☐ W00 – Free Medical, No Rx Co-pay ☐ W05 – Free Medical, Rx Co-pay*

☐ W40 – Pays 40% of Medical, Rx Co-pay* ☐ X50 – Discount Policy Program

*Rx Co-pay - $3 per prescription & $15 max. per day. (Prescriptions can only be filled at Highland Pharmacy)

The Charity Care / Discount Policy Programs only cover ACMC charges. Charity Care / Discount Policy Programs do not cover any professional fee medical bill for physicians who are not employed by ACMC, prescriptions filled at outside pharmacies, lab work processed at outside labs, ambulance charges, or any other services provided outside of ACMC.

Check appropriate box for Identification / Income Verification.
Identification Verification: Include ID Number and/or Issue/Expiration Date.
Income Verification: Include dates of verification documents.

Comments:

	IDENTIFICATION / ADDRESS VERIFICATION		INCOME VERIFICATION
☐	Driver's License	☐	Paycheck stubs
☐	Voter's Registration Card with picture	☐	Award letter / checks – Pensions, Soc. Sec., VA
☐	Check Cashing card with photo	☐	Statement of other income: (contributions, refunds, child support, etc)
☐	Soc. Sec. Card or Soc. Sec. document	☐	State Unemployment / Disability award letter / application
☐	Birth Certificate	☐	Student Loan letter / loan grant papers
☐	School ID Card	☐	Self-employment info: Last year's income tax documents current ledgers / inventory incl. equipment / supplies
☐	US Citizenship / Alien Status documents (passport)		
☐	Marriage record	☐	Unemployment check stubs
☐	Divorce decree	☐	Disability check stubs
☐	Work / Building pass	☐	Worker's Comp check stubs
☐	VISA	☐	Retirement check stubs
☐	Tribal Enrollment Card	☐	Income Tax Documentation (Prior Yr.)
☐	Church membership / baptism / confirmation record	☐	Other Income – Savings account: annuity statements, etc. (Do not include IRA's or deferred compensation retirement plans)
☐	Other Written Documentation (Specify)	☐	Free Room and Board Statement
		☐	Sworn Statement
		☐	Other Written Documentation (Specify)

I declare under penalty of perjury that all of the information given on this form is true and correct to the best of my knowledge and belief. I understand my financial liability under the Alameda County Medical Center's Charity Care / Discount Policy Programs as determined by the Charity Care / Discount Policy Program Fee Schedule.

I agree to notify this facility of any changes in my financial circumstances and to provide upon request, information verifying my eligibility status.

Patient / Payor Signature		Date
Representative for Patient	Relationship	Date
Interviewed By		Date
Approved By		Date

White – File Copy – Patient