Charity Guidelines

CHARITY CARE AND LOW INCOME FINANCIAL ASSISTANCE APPLICATION AND GUIDELINES

Poverty Guideline	Family Size	100%	250%	350%
10,830	**1**	**10,830**	**$27,075**	**$37,905**
14,570	**2**	**14,570**	**36,425**	**$50,995**
18,310	**3**	**18,310**	**45,775**	**$64,085**
22,050	**4**	**22,050**	**55,125**	**$77,175**
25,790	**5**	**25,790**	**64,475**	**$90,265**
29,530	**6**	**29,530**	**73,825**	**$103,355**
33,270	**7**	**33,270**	**83,175**	**$116,445**
37,010	**8**	**37,010**	**92,525**	**$129,535**
40,490	**9**	**40,490**	**101,225**	**$141,715**
43,970	**10**	**43,970**	**109,925**	**$153,895**
47,450	**11**	**47,450**	**118,625**	**$166,075**
50,930	**12**	**50,930**	**127,325**	**$178,255**
54,410	**13**	**54,410**	**136,025**	**$190,435**
57,890	**14**	**57,890**	**144,725**	**$202,615**
61,370	**15**	**61,370**	**153,425**	**$214,795**
64,850	**16**	**64,850**	**162,125**	**$226,975**
68,330	**17**	**68,330**	**170,825**	**$239,155**
71,810	**18**	**71,810**	**179,525**	**$251,335**
75,290	**19**	**75,290**	**188,225**	**$263,515**
78,770	**20**	**78,770**	**196,925**	**$275,695**
Add for each additional member		**3,480**	**8,700**	

Number of family members: ______ <-------- Enter number of family members

Annual Income ______ <-------- Enter total gross annual income

Los Angeles Community Hospital

Statement

I certify that the information provided is true and accurate to the best of my knowledge. Further, I have or will apply for any assistance (MediCal, Medicare, insurance, etc.) which may be available for payment of medical services, and that I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for medical services.

I understand that this application is made for the hospital to evaluate eligibility for charity services. I also understand that the hospital will verify the information which may include obtaining a credit report. If the information I have given proves to be untrue, or if I fail to comply with the referral process for MediCal, Medicare, California Children's Services, or other identified programs this will result in forteiture of the right to be considered for Charity Care.

Date:_____________________

Signature:____

Name:____

Address:____

____

____

Telephone Number:____

Unemployed Attestation Form

I hereby acknowledge that I am currently unemployed and all information provided herein is true and correct to the best of my knowledge. If I am receiving unemployment compensation, I will attach a copy of my unemployment checkstub. I understand that providing false information will result in denial of this Application. Additionally depending upon local and states statutes, providing false information to defraud a hospital for obtaining goods or services may be considered an unlawful act. I also ackknowledge and consent that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Los Angeles Community Hospital Charity Care program is a "Payer of Last Resort" and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for fitness or injury, for which Los Angeles Community Hospital provided care.

Date:_____________________

Signature:____

Name:____

Address:____
____
____

Telephone Number:____

Homeless Affidavit

I hereby acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in denial of this Application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services may be considered an unlawful act. I also acknowledge and consent that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Los Angeles Community Hospital Charity Care program is a "Payer of Last Resort" and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for fitness or injury, for which Los Angeles Community Hospital provided care.

Date:_____________________

Signature:____

Name:____

Address:____

____

____

Telephone Number:____

Los Angeles Community Hospital reserves the right to bill third party if appropriate.

Application Instructions

The following information and supporting documents must be provided to evaluate this application
for a possible reduction of hospital expenses provided by Los Angeles Community Hospital.

Please complete all sections of the application and provide one or more of the applicable documents. Return the application to the admitting department or return to the Business Office at the address listed below:

Los Angeles Community Hospital
FILE 51125
Los Angeles, Ca. 90074-1125

If you should need to contact the hospital regarding your application please call (562) 804-5830.

List of documents required to complete Charity Application:

Proof of Gross Income

*Check Stubs
*Employers statement of earnings
*W-2 form
*Income Tax returns
*Profit/loss statement from accountant (if self employed)
*Homeless Affidavit
*Unemployed Attestation
*Social Security / Disability
*Workers Compensation
*Strike Benefits
*Welfare/AFDC/General Relief
*Veteran's Benefits
*Stipends
*Alimony
*Child Support
*Military Family Allotments
*Private or Government Pensions
*Proceeds from Insurance or Annuity Payments
*Income from Dividends
*Interest Income
*Rents
*Royalties
*Farm Income (after expenses)
*Support from Family Members or someone not living in the household

*Assets
*Bank Statement

If no proof of income, please submit a copy of recent tax return.

Personal Information

Patient Name:			
Patients place of birth:		**Account Number:**	
Guarantor Name:			
Address:			
Does the patient have medical insurance?	**Yes**	**No**	**Name:**
Is patient a California Resident?	**Yes**	**No**	
County of Residence:			
Total family members:			

Name	Age	Date of Birth	Social Security Number	Relationship to Patient

Los Angeles Community Hospital

Assets/Income/Resources

Employee/Employer Name	Employer Information	Monthly Income (prior to taxes)
Employee Name: Telephone Number:	Address:	$ -
Employee Name: Telephone Number:	Address:	$ -
Employee Name: Telephone Number:	Address:	$ -
Employee Name: Telephone Number:	Address:	$ -
		$ -

Funds	Investments
Checking:	**Money Market Funds:**
Savings:	**Stocks:**
	Bonds:

Monthly Expenses Information

Rent/Mortgage	Monthly Payment
	Amount:
Utilities	**Monthly Payment**
Gas:	Amount:
Electric:	Amount:
Telephone:	Amount:
Other:	Amount:
Other:	Amount:
Medical Insurance Payments	**Monthly Payment**
Name:	Amount:
Car Payment	**Monthly Payment**
Name:	Amount:
Automobile/Transportation Expenses	**Monthly Payment**
Insurance:	Amount:
Gas:	Amount:
Repair/Maintenance:	Amount:
Bus Fare:	Amount:
Other:	Amount:
Food	**Monthly Payment**
	Amount:
Credit Cards/Loans	**Monthly Payment**
Name:	Amount:
Name:	Amount:
Name:	Amount:
Other Monthly Expenses	**Monthly Payment**
Name:	Amount:
Name:	Amount:

Total: **$ -**