



**FINANCIAL ASSISTANCE PROGRAM FOR LOW INCOME
UNINSURED PATIENTS
FREQUENTLY ASKED QUESTIONS**

How do I determine whether I qualify for financial assistance for my hospital medical bills?

Federal Poverty Guideline			
Family Size	Poverty Guide	200%	350%
1	\$ 10,890.00	\$ 21,780.00	\$ 38,115.00
2	\$ 14,710.00	\$ 29,420.00	\$ 51,485.00
3	\$ 18,530.00	\$ 37,060.00	\$ 64,855.00
4	\$ 22,350.00	\$ 44,700.00	\$ 78,225.00
5	\$ 26,170.00	\$ 52,340.00	\$ 91,595.00
6	\$ 29,990.00	\$ 59,980.00	\$ 104,965.00
7	\$ 33,810.00	\$ 67,620.00	\$ 118,335.00
8	\$ 37,630.00	\$ 75,260.00	\$ 131,705.00
Ea. Add. Person Add \$3,820.00			

Palm Drive Hospital offers Charity Care or Discount Payment options to our low-income, uninsured patients that meet the program eligibility requirements.

If your family income is below 200% of the Federal Poverty Income Guideline, you may qualify for Charity Care (the hospital will write-off 100% of your charges).

If your family income is between 201% and 350% of the Federal Poverty Income Guideline, you may qualify for a Discount Payment option, leaving a nominal balance as your responsibility.

If your family income is below 350% of the Federal Poverty Income Guideline and you have high medical costs (annual hospital costs exceeding 10% of your family income), you may qualify for either Charity Care or Discounted Payment option.

The Business Office will begin the eligibility determination process once they have received a completed application form along with your family income verification documents. Failure to submit a completed application and supporting family income documentation may result in a denial of Charity Care or Discounted Payment.

How do I apply for Financial Assistance?

Complete the “Statement of Financial Condition” form on the other side of this document and return it to the Business Office at:

**Palm Drive Hospital
Business Office
501 Petaluma Avenue
Sebastopol CA 95472**

You must provide family income documentation, such as pay stubs, tax return or employer salary history with your application in order for the hospital to determine your eligibility.

The Business Office will process your application and may contact you as part of the application process (if additional information is necessary). If you need assistance completing the form, you may contact the business office at: **(707) 829-4025**.

How will I be notified of my application determination?

Once the eligibility review of your application is complete, you will receive a "Notification Letter" in the mail. This letter will indicate your eligibility status and any remaining balance that is your responsibility. If any discounts have been applied, they will be listed on the letter.



STATEMENT OF FINANCIAL CONDITION

Patient Name _____ SSN: _____

Spouse: _____ SSN: _____

Address: _____

City/State/Zip: _____

Account#(s): _____ Phone#: (____) _____

A FAMILY SIZE: _____ (Include self, spouse and all dependents).
List all dependants that you support

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

B EMPLOYMENT (If self employed, give business name)

Employer: _____ Position: _____

Spouse Employer: _____ Position: _____

C CURRENT MONTHLY INCOME

Must supply proof of income (pay stubs, tax return, etc).

	Patient	Spouse
1) Net Pay (Gross less all deductions)	_____	_____
2) Income from operating business (if self employed)	_____	_____
3) Other income	_____	_____
4) Interest and dividends	_____	_____
5) Social Security income	_____	_____
6) Other	_____	_____

Total Current Monthly Income _____

By signing this form, I agree to allow Palm Drive Hospital to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I may be requested to provide proof of the information I am providing.

_____ Signature of Patient or Guarantor	_____ Date	_____ Signature of Spouse	_____ Date
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