KERN MEDICAL CENTER

AFFILIATED WITH UNIVERSITY OF CALIFORNIA SCHOOLS
OF MEDICINE AT LOS ANGELES, SAN DIEGO, AND IRVINE

Dear Patient:

On (Appointment Date) , you or a family member received medical treatment at Kern Medical Center. Kern Medical Center is a general hospital operated by the County of Kern. The hospital is required to charge for all services it provides. **If you are unable to pay for medical services, you may be eligible for one of the following programs. If you wish to apply under the program, you should take this letter to the office that is checked. Application must be made within ten days of this referral.**

☐ **MEDI-CAL:** You may apply for Medi-Cal at Kern Medical Center in the Department of Human Services located by the West side entrance of the hospital.

Department of Human Services (Medi-Cal)
Open 7:00 A.M. - 3:00 P.M., Monday - Friday, Closed holidays and weekends.
If you wish to schedule an appointment to complete the application, please call 326-2840.

☐ **MEDICALLY INDIGENT ADULT PROGRAM (MIA):** You may apply for "MIA" in the Financial Services trailer #1, located by the West side entrance of the hospital. Proof of eligibility will be requested when you return for additional services.

Financial Services (MIA), Trailer #1
Open 8:00 A.M. - 4:00 P.M., Monday - Friday, Closed holidays and weekends.
You must schedule an appointment to complete the application, please call 326-2392.

Listed below are the majority of items needed for most persons to determine eligibility. Bring items that you think may be of assistance in determining eligibility. Additional items may be needed in some cases in order to determine eligibility. If needed, these additional items will be requested by the interviewer.

1. Valid picture identification
2. Social Security card for all family members
3. Verification of *all* income in household
    - A. Earnings
    - B. Unemployment Income (UIB)
    - C. State Disability Income (SDI)
    - D. Social Security Income (SSI)/Social Security Disability (SSD)
    - E. Other
4. Rent receipts, if renting
5. Current property tax statement, if buying
6. Vehicle registrations (car, motorcycle, trailer, motorhome, etc.)
7. All insurance policies
8. Record of application or denial for Social Security Disability (SSD), Social Security Income (SSI), Medi-Cal, Unemployment Income (UIB), State Disability Income (SDI), Workman Comp. Income (WCI)
9. Verification of checking/ savings accounts (five years history may be required).

Failure to complete this application and nonpayment for service may result in your account being referred to a Collection Agency.

The undersigned agrees, whether signing as patient or as representative, that this is a *Letter of Referral* and in order to have a determination of eligibility made, a fact to face interview is required ON the next visit or before (Date) .

Received by _____

Clerk _____ Date _____

KMC 580 8997 1538 (5-96)

COUNTY OF KERN
KERN MEDICAL CENTER
FINANCIAL STATEMENT

1. APPLICANT'S NAME — FIRST — MIDDLE — LAST

2. HOME ADDRESS — NUMBER — STREET — CITY — ZIP

MAILING ADDRESS (if different from above)

HOME PHONE — WORK PHONE — MESSAGE PHONE

3. FAMILY MEMBERS

3A. LIST YOURSELF AND YOUR SPOUSE IF LIVING IN THE HOME.

NAME (First, middle, last) / SS NO.	Sex	Birthdate Mo/Day/Year / BIRTHPLACE	Marital Status	MEDI-CAL #	
YOURSELF SS NO. / ALIEN REG. NO.		/ /			
SPOUSE SS NO. / ALIEN REG. NO.		/ /			

3B. LIST ALL YOUR AND YOUR SPOUSE'S UNMARRIED CHILDREN UNDER 21.

CHILD'S NAME / SS NO.			MEDI-CAL #	
CHILD'S NAME SS NO. / ALIEN REG. NO.		/ /		
CHILD'S NAME SS NO. / ALIEN REG. NO.		/ /		
CHILD'S NAME SS NO. / ALIEN REG. NO.		/ /		

3C. Are you or any family member for whom you are requesting service claimed as a deduction for income tax purposes by someone else? Yes ( ) No ( )

4. Is there anyone other than you or your immediate family members living with you, such as roommate or relative?
Yes ( ) No ( )

5. Are any of the persons listed in 3A or 3B aliens? Yes ( ) No ( )

6. Are you a resident of Kern County? Yes ( ) No ( )

7. Do you currently pay housing and utility costs? Yes ( ) No ( )

8. Do you or family member own a motor vehicle? Yes ( ) No ( )

CO: USE ONLY
Case Name:

Case Number:

App/RV date:

Verification of identity:

Verification of Residence:

Verification and value of exempt motor vehicle:

Verification and value of additional motor vehicles:

TOTAL VALUE: _____

KMC 580 8997 1389 (Rev. 3/90)

9. Do you or any of your family own real property? (Examples: House, land, building, mobile home) Yes ( ) No ( )

CO. USE ONLY

Verification:

Address _____

Full market value	$_____	Yearly ( )	Monthly ( )
Amount owed	$_____	Yearly ( )	Monthly ( )
Rent collected each month	$_____	Yearly ( )	Monthly ( )
Interest paid	$_____	Yearly ( )	Monthly ( )
Taxes and assessments	$_____	Yearly ( )	Monthly ( )
Utilities	$_____	Yearly ( )	Monthly ( )
Insurance	$_____	Yearly ( )	Monthly ( )

Total Property

Verification:

10. List all your assets and the assets of family members. If none, check none.	NONE	AMOUNT	SELF	SPOUSE	CHILDREN
A. Money on hand					
B. Money in checking account					
C. Money in savings account					
D. Money in safe deposit box					
E. Stocks or bonds					
F. Notes, mortgages, deeds of trust					
G. Life insurance					
H. Other					

Total Assets:

11. Do you or any family member have any of the following sources of income? If none, check none.					
A. Unemployment benefits					
B. Disability benefits					
C. Veterans benefits					
D. Pension					
E. Money from someone outside the home					
F. SSI/SSP, AFDC, GR					
G. Social Security					
H. Worker's Compensation					
I. Military Allotment					
J. Payment from roomers					
K. Monetary gifts/contributions					
L. Interest/dividends					
M. Food Stamps					
N. Other					

Verification:

Total Unearned Income:

12. Have you or your spouse been employed at any time during this month? Yes ( ) No ( ) If yes, complete the following:

	Applicant	Spouse
A. Name of employer		
B. Address of employer		
C. Hours of work/week		
D. How often paid		
E. Day of week paid		
F. Gross earnings/pay period		

Verification:

13. If currently unemployed, give date and place of last employment.

_____ _____ Applicant

_____ _____ Spouse

(Date) (Employer)

CO. USE ONLY

UIB?

Yes No

14. Do you have a physical or emotional problem which makes it difficult for you to work? Yes ( ) No ( )
If yes, are you:
(check appropriate box)

A. Physically able to follow usual occupation? ( )
B. Physically able to do light work — full time ( )
C. part time ( )
C. Physically incapacitated for any type of work?. ( )

( ) Permanently ( ) Temporarily

Referred for:

SSI/SSP _____
DIB _____
DED _____
AFDC/MN_____

15. Do you or your spouse have health or hospitalization insurance? Yes ( ) No ( ) If yes, complete the following:

Verification:

Name of Coverage	Person Insured

I declare under penalty of perjury that the information given on this application is true and correct to the best of my knowledge and belief. I agree to notify the Kern County: KERN MEDICAL CENTER of any change in my circumstances and to provide upon request information necessary to verify my eligibility status. I understand that my income and assets will be verified.

Rights and responsibilities reviewed

_____
Date

Signature of Applicant		Date
Signature of Person Acting for Applicant	Relationship	Date
Signature of Witness (if signed with mark)		Date
Signature of Interviewer		Date

KMC 580 8997 1389 (Rev. 3/90) (Pg. 3 of 3)

M.I.A. LINKAGE EVALUATION

TO HELP US DETERMINE YOUR ELIGIBILITY FOR THE M.I.A. ASSISTANCE PROGRAM, PLEASE ANSWER THE FOLLOWING QUESTIONS.

1. Are you, or a family member, a Native-born or Naturalized U.S. citizen? YES ___ NO___
   If No, do you or the family member(s) have a green card? YES ___ NO___

   If No, is the service you're requesting Emergency or Pregnancy related? YES ___ NO___

   (If Yes, refer to Medi-Cal.)

2. Have you applied for amnesty? YES ___ NO___
   Do you have an amnesty card? YES ___ NO___

3. Are you under 21 years of age? YES ___ NO___
   If Yes:
   State Law provides that a child under 21 years of age, may without parental consent, apply for Medi-Cal to receive services related to Pregnancy, sexual assault, venereal disease, drug or alcohol addiction, mental health, family planning and sexually transmitted diseases.

   I request Medi-Cal, without my parents consent, for services related to:

   ___Pregnancy and/or Family Planning
   ___Sexual Assault
   ___Venereal Disease
   ___Drug or Alcohol Addiction
   ___Mental Health
   ___Sexually Transmitted Diseases

4. Are you 65 years of age or older? YES ___ NO___

5. Are you legally blind? YES ___ NO___

6. Are you unable to work because of a physical or mental illness, disability or impairment, that is expected to continue longer than one year and cause you to be permanently and totally disabled? YES ___ NO___

7. HAVE YOU OR ANY FAMILY MEMBER EVER APPLIED FOR OR RECEIVED

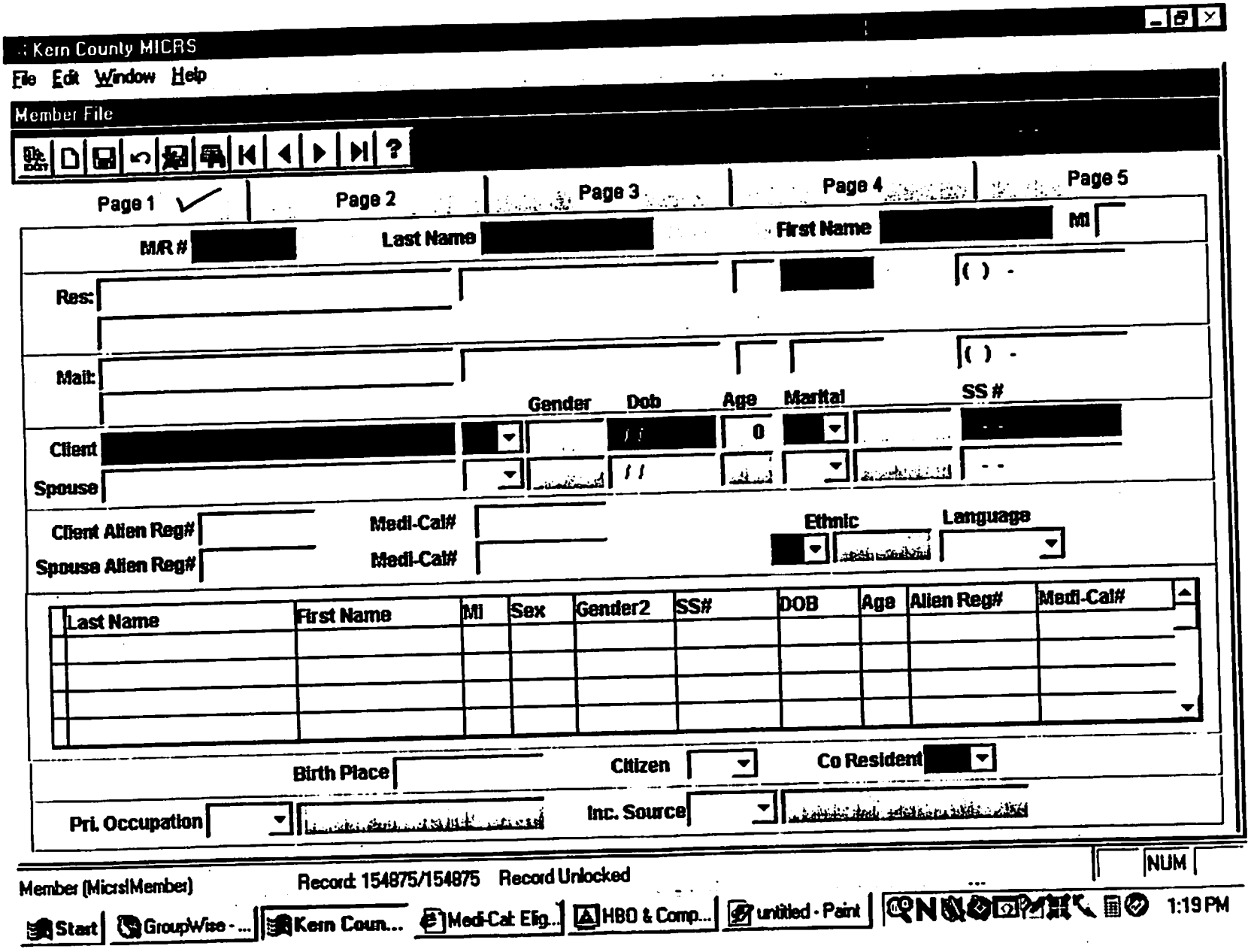
   AFDC Cash Assistance YES NO Medi-Cal YES NO Other Welfare Benefits YES NO
   SSI/SSP Check YES NO Food Stamps YES NO
   If you answered YES on any item, complete the following:

Name of Person(s) Who Applied for or Received Aid	Type of Aid	Date of App. (Mo/Day/Yr)	Place of Application (County/State)	Date Last Rec'd (If no longer receiving) (Mo/Day/Yr)	Reason for Discontinuance

8. Are you pregnant? YES ___ NO___

9. Are there children younger than 21 years of age living in your home? YES ___ NO___
   If NO, A and B does not apply.
   A. If YES, are any of the children a child in-common with your current spouse? YES ___ NO___
   B. If YES, is one of the child's parents:
      ___Deceased?
      ___Not Living in the home?
      ___Unemployed?
      ___Legally Blind?
      ___Currently unable to work because of physical or mental impairment?

10. Do you live in a Skilled Nursing/Intermediate Care Facility? YES ___ NO___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MR #
Last Name
First Name
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Dob
Age
Marital
SS #
Client
Spouse
Client Alien Reg#
Spouse Alien Reg#
Medi-Cal#
Medi-Cal#
Ethnic
Language
Last Name
First Name
MI
Sex
Gender2
SS#
DOB
Age
Alien Reg#
Medi-Cal#
Birth Place
Citizen
Co Resident
Pri. Occupation
Inc. Source
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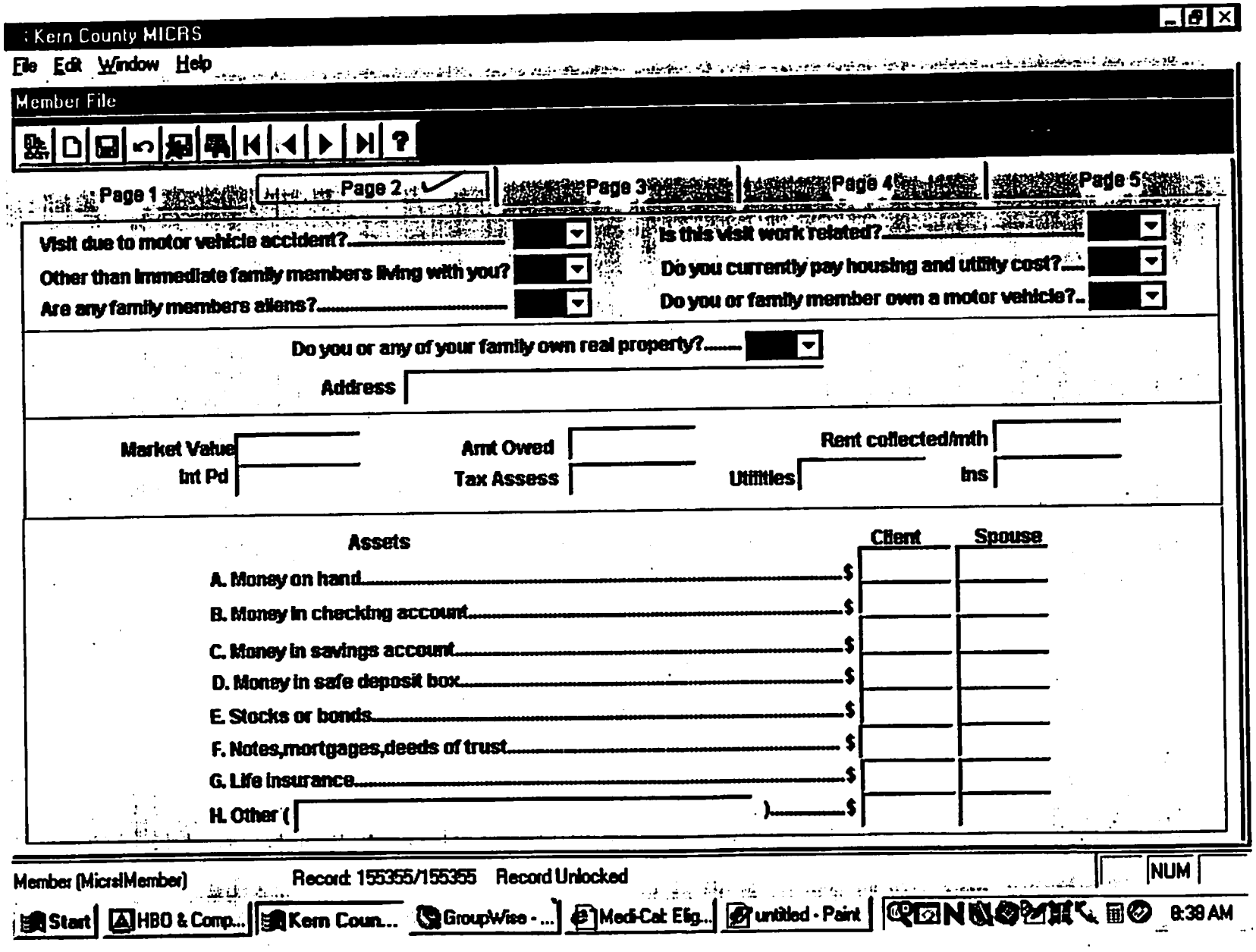
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Visit due to motor vehicle accident?
Other than immediate family members living with you?
Are any family members aliens?
Is this visit work related?
Do you currently pay housing and utility cost?
Do you or family member own a motor vehicle?
Do you or any of your family own real property?
Address
Market Value
Int Pd
Amt Owed
Tax Assess
Rent collected/mth
Utilities
Ins
Assets
Client
Spouse
A. Money on hand
B. Money in checking account
C. Money in savings account
D. Money in safe deposit box
E. Stocks or bonds
F. Notes,mortgages,deeds of trust
G. Life insurance
H. Other (
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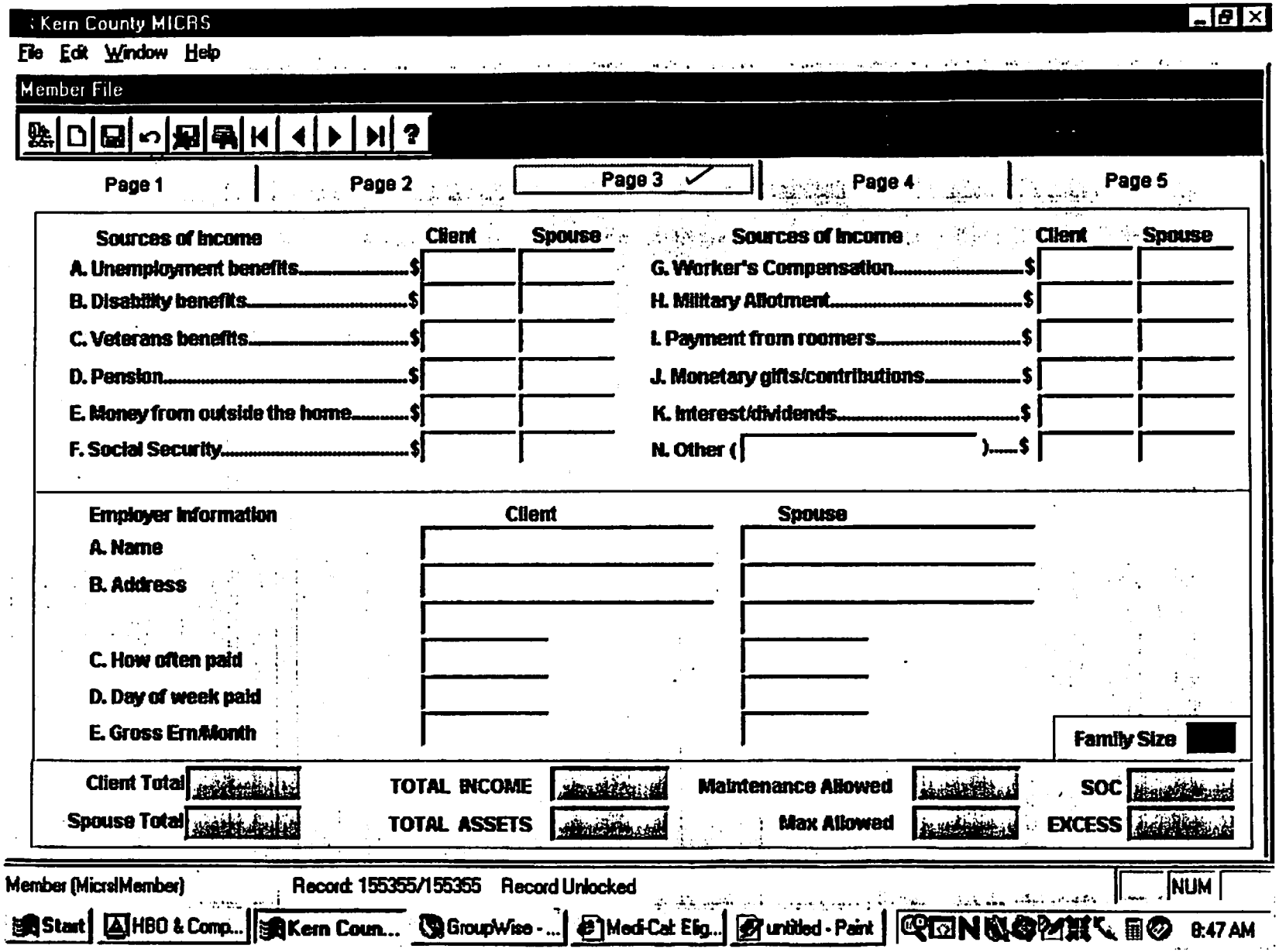
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Sources of Income
Client
Spouse
A. Unemployment benefits $
B. Disability benefits $
C. Veterans benefits $
D. Pension $
E. Money from outside the home $
F. Social Security $
Sources of Income
Client
Spouse
G. Worker's Compensation $
H. Military Allotment $
I. Payment from roomers $
J. Monetary gifts/contributions $
K. Interest/dividends $
N. Other ( ) $
Employer Information
Client
Spouse
A. Name
B. Address
C. How often paid
D. Day of week paid
E. Gross Ern/Month
Family Size
Client Total
Spouse Total
TOTAL INCOME
TOTAL ASSETS
Maintenance Allowed
Max Allowed
SOC
EXCESS
Member (MicrsIMember)
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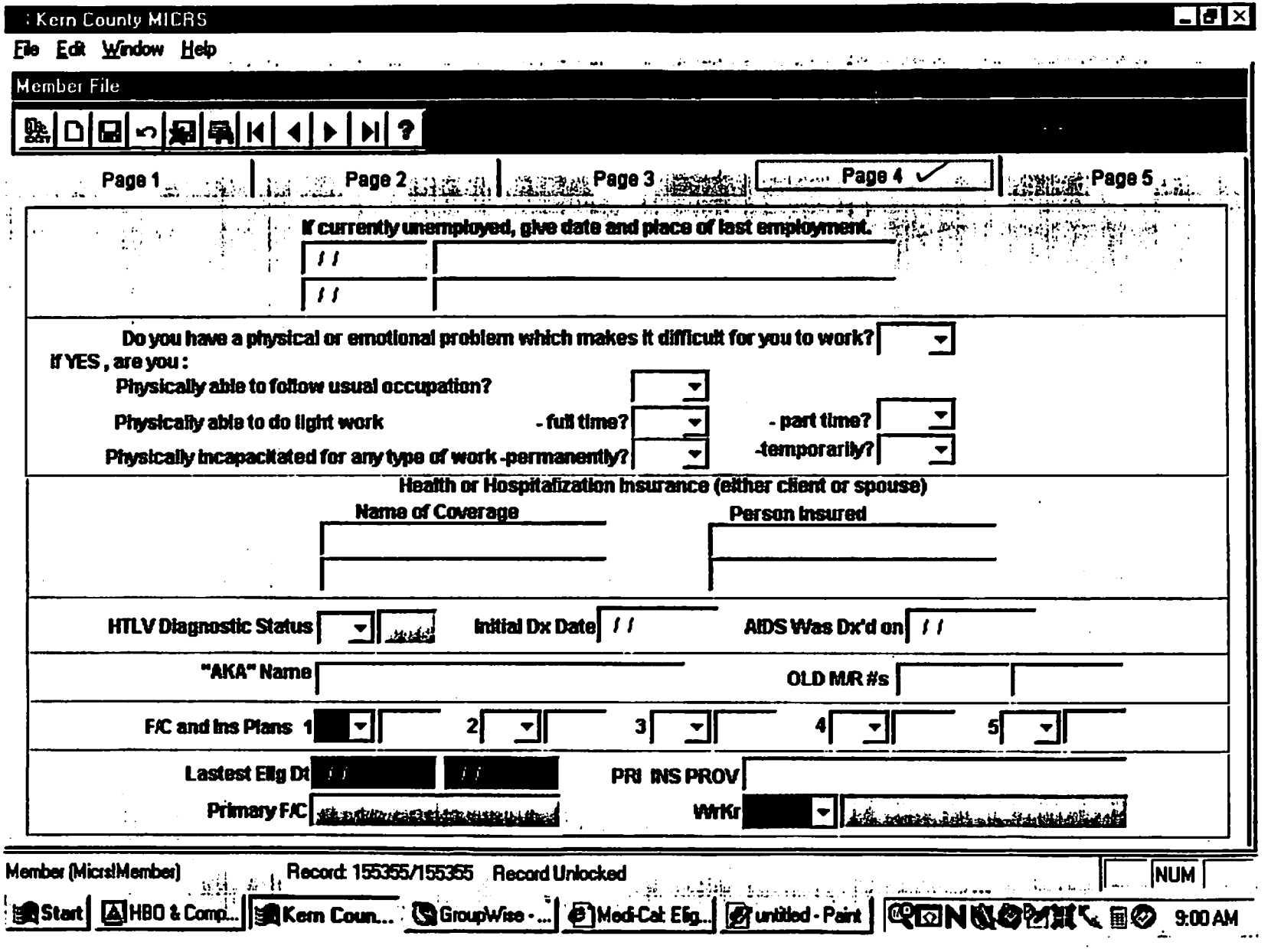
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If currently unemployed, give date and place of last employment.
Do you have a physical or emotional problem which makes it difficult for you to work?
If YES, are you:
Physically able to follow usual occupation?
Physically able to do light work
- full time?
- part time?
Physically incapacitated for any type of work -permanently?
-temporarily?
Health or Hospitalization Insurance (either client or spouse)
Name of Coverage
Person Insured
HTLV Diagnostic Status
Initial Dx Date
AIDS Was Dx'd on
"AKA" Name
OLD MR #s
F/C and Ins Plans 1
2
3
4
5
Lastest Elig Dt
PRI INS PROV
Primary F/C
WrKr
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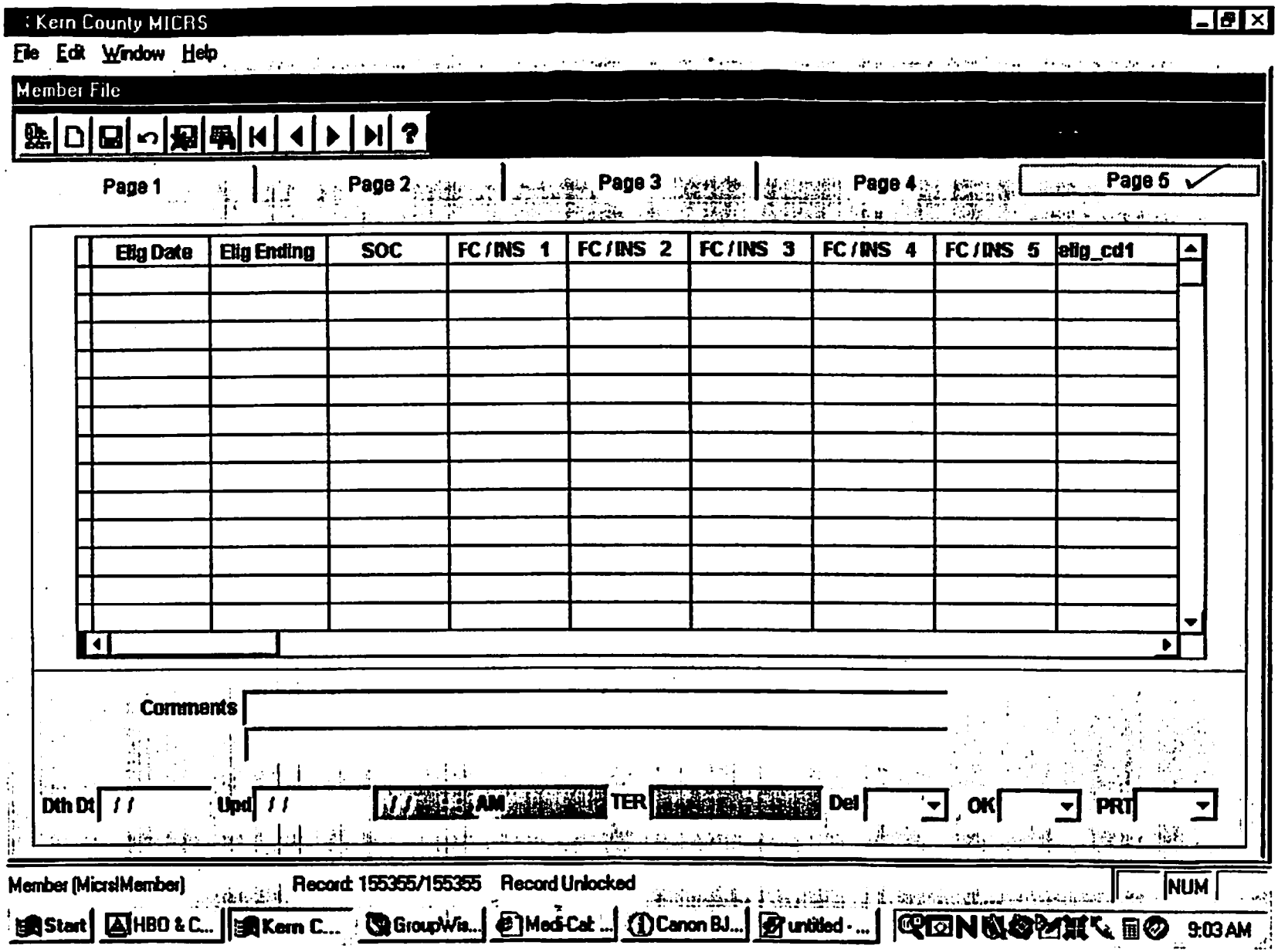
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Elig Date
Elig Ending
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FC / INS 4
FC / INS 5
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KERN MEDICAL CENTER

AFFILIATED WITH UNIVERSITY OF CALIFORNIA SCHOOLS
OF MEDICINE AT LOS ANGELES,SAN DIEGO AND IRVINE

SHARE OF COST INFORMATION

Patient's Name:

Patient's Medical Record Number:

For those patients who do not qualify for Medi-Cal they may be eligible for alternative assistance from the County of Kern through the Medically Indigent Program(MIA) administered at Kern Medical Center.

The charges to you for services provided at Kern Medical Center are dependent on your eligibility and financial status. Your eligibility and/or Share of Cost is determined by reviewing your financial records and is available from the Accounts Receivables Department.

A preliminary indication of your Share of Cost is based on the following information:

MONTHLY INCOME:
PERSONAL PROPERTY:
NUMBER IN HOUSEHOLD:

Based on this information, your total **Share of Cost is**:
Financial Classification is and Insurance Plan #
This letter is effective **and expires**

Your eligibility and Share of Cost may be redetermined based on additional information.It is the patient's responsibility to provide the MIA program with necessary information to determine eligibility for the MIA program. Services that are not a benefit of the Medi-Cal Program are excluded from this special assistance program and require full payment by the patient.

The MIA program will pay for covered medical services only if received at KMC after issuance of this letter. **All health care charges obtained prior to the issuing of this letter are the patient's responsibility.** In the event that Kern Medical Center cannot provide the care, and the health care required is a covered benefit of the program, KMC will make arrangements to provide the necessary care. Prior authorization is required from the Case Management Department at Kern Medical Center. **All health care charges incurred outside KMC without prior authorization by the Case Management Department are the patient's responsibility.**

Once Medi-Cal or your Disability Claim has been granted, you will no longer be eligible for the MIA benefits as outlined above.

I acknowledge that the above information provided by me is true and that it is a preliminary indication of my MIA and/or Share of Cost status.

Patient or Responsible Party: _____

By:
Issue Date: