Community Hospital
of the Monterey Peninsula
Montage Health

APPLICATION FOR SPONSORED CARE OR DISCOUNT PAYMENT PROGRAM

This is an application for the Sponsored Care and Discount Payment programs.

To be considered for financial assistance, a completed application must be submitted to our office no later than 240 days from the original bill date. Due to the length of time allowed to submit an application, late submissions will not be considered.

Please be sure to attach required documentation as indicated on the application.

This program is the payer of last resort and should only be accessed after all other means of payment have been exhausted. This means that you need to apply for any and all government programs for which you may be eligible, such as Medicare, Medi-Cal and the California Health Benefit Exchange. Enrollment Counselors are available at Community Hospital to help you through the application process for most government programs.

If you apply and are deemed eligible by Community Hospital for Sponsored Care or the Discount Payment Program, you will be notified of the discount amount for which you have been approved. This program does not cover fees and charges from other providers (including physicians) for which Community Hospital does not bill. It also does not cover transportation (i.e. ambulance).

If you have questions regarding the completion of your application please call us at any of these numbers:

For information **prior** to care or services:
Social Services
(831) 622-2722

For information **during** care:
Patient Access
(831) 625-4910

For information **after** care:
Patient Business Services
(831) 625-4922

APPLICATION TO DETERMINE SPONSORED CARE OR DISCOUNT PAYMENT PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if independent and age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for Community Hospital 's Sponsored Care Program or Discount Payment Program. The term "applicant" means the patient for whom Community Hospital provided or will provide medical services. Please type or print clearly.

A. APPLICANT INFORMATION

1. Name of applicant (Last, first, middle): _____
2. Any other name the applicant is known by: _____
3. Date of birth (Month, day, year): _____
4. Social Security number: _____
5. Residence address:

_____

Number and street (do not use P.O. Box) City State Zip

6. Mailing address (if different from residence):

_____

Number and street (do not use P.O. Box) City State Zip

7. Daytime phone number: _____ 8. Evening phone number: _____
9. Message phone number: _____
10. What language do you speak at home? _____
11. Type of service provided or requested: _____
12. The Sponsored Care and Discount Payment programs require submission of the following documentation:
    - Completed application form
    - Proof of income:
        - Copy of signed tax return from the most recent tax year
        - Pay stubs from the past 3 months, for all members of the family
        - Copy of most recent W2 form (Sponsored Care Program only) for the following family members: spouse, domestic partner, dependent children, and parent if applicant is a minor.
    - Proof of medical insurance or eligibility for California Health Benefit Exchange
    - Medi-Cal program linkage determination, if applicable
    - Health insurance denial, if applicable

    You may be asked to provide additional documentation, including but not limited to the following:
    - Proof of out-of-pocket medical, dental, pharmacy, and insurance premium expenses, such as receipts
    - Additional supporting documentation of lack of income

B. PARENT/LEGAL GUARDIAN INFORMATION (Applicants age 18 or older or emancipated minors skip items 13 through 18)

13. Name(s) of parent or legal guardian:_____ Relationship: _____

14. Residence address:

_____

Number and street (do not use P.O. Box) City State Zip

15. Mailing address (if different from residence):

_____

Number and street (do not use P.O. Box) City State Zip

16. Daytime phone number:_____ 17. Evening phone number: _____

18. Message phone number: _____

C. HEALTH INSURANCE INFORMATION

19. Does the applicant have Medi-Cal? If yes, what is the applicant's Medi-Cal ID number?

20. Does the Applicant have other health insurance including but not limited to:

- Third Party insurance coverage
- Eligibility or active coverage with the California Health Benefit Exchange

21. Total paid out of pocket medical expenses for the past 12 months $_____ attach proof of payment

D. INCOME INFORMATION (Report income for the following family members: spouse, domestic partner, parent, and dependent children. Attach additional sheets if necessary.)

22. Number of family members (including applicant) in your home you can claim on your income tax: _____

Name of family member	Employer	Student status Yes or No Full-time or Part-time	Gross income for last 12 months	Income most recent tax year

E. ASSET INFORMATION (Complete this section only if you are applying for the Sponsored Care Program)

Report the current value of your monetary assets. Attach additional sheet if necessary.
Supporting documents may be required.

	Value	Account number	Name/address of institution
Cash			
Checking account			
Savings account			
Certificate of deposit			
Brokerage account			
Non-tax-deferred securities and investments			
Precious metals/jewelry			
Assets held in trust			
Other monetary assets			

_____ Initial here	I am applying for the hospital's Sponsored Care or Discount Payment Program as indicated above. I understand that failure to provide requested information by the due date will result in denial of my application.
_____ Initial here	I certify that I have read and understand the information on this application.
_____ Initial here	I certify that the information I have given on this form is true and correct.
_____ Initial here	I give my permission for Community Hospital of the Monterey Peninsula to contact any healthcare provider regarding my medical care and treatment.
_____ Initial here	I understand and agree that a credit report will be run on all Sponsored Care requests. Other verifications such as employment and property ownership searches may be conducted at the hospital's discretion.

Additional comments: _____

_____

_____

_____

_____ _____

Applicant's signature Today's date