# Exhibit C
# STATEMENT OF FINANCIAL CONDITION/FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME _____ SPOUSE _____
ADDRESS _____
PHONE _____
ACCOUNT # _____ SSN: _____ _____
(PATIENT) (SPOUSE)

**FAMILY STATUS**: List all dependents that you support

| Name | Age | Relationship |
|---|---|---|
| _____ | ____ | _____ |
| _____ | ____ | _____ |
| _____ | ____ | _____ |

**EMPLOYMENT AND OCCUPATION**

Employer: _____ Position: _____
Contact Person & Telephone Number: _____
If Self-Employed, Name of Business: _____

Spouse Employer: _____ Position: _____
Contact Person & Telephone Number: _____
If Self-Employed, Name of Business: _____

**CURRENT MONTHLY INCOME**

| | | Patient | Spouse |
|---|---|---|---|
| | Gross Pay (Before Deductions) | _____ | _____ |
| Add: | Income from Operating Business (if Self-Employed) | _____ | _____ |
| Add: | Other Income | _____ | _____ |
| | Interest & Dividends | _____ | _____ |
| | From Real Estate | _____ | _____ |
| | Social Security | _____ | _____ |
| | Other (Specify) | _____ | _____ |
| | Alimony or Spousal Support | _____ | _____ |
| Subtract: | Alimony, Support Payments Paid | _____ | _____ |
| Equals | Current Monthly Income | _____ | _____ |

Total Current Monthly Income (Patient + Spouse) = $ _____

FAMILY SIZE

Total Family Members: _____
(add patient, spouse and dependents from above)

| | Yes | No |
|---|---|---|
| Do you have health insurance? | ____ | ___ |
| Are you eligible for any government programs? | ____ | ___ |
| Do you have other insurance that may apply (such as auto policy)? | ____ | ___ |
| Were your injuries caused by a third party? (such as during car accident)? | ____ | ___ |

By signing this form, I agree to allow St. Rose Hospital to check employment status and credit history for the purpose of determining my eligibility for financial assistance. I understand that I may be required to provide proof of the information I am providing.

_____ _____
(Signature of Patient or Guarantor) Date

_____ _____
(Signature of Spouse) Date

**Exhibit D**

**CHARITY CARE CALCULATION WORKSHEET**

Patient Name: _____ Patient Account #: _____

Special Considerations/Circumstances:

_____
_____
_____
_____

| | Yes | No |
|---|---|---|
| Does Patient have Health Insurance? | ____ | _____ |
| Is Patient Eligible for Medicare? | ____ | _____ |
| Is Patient Eligible for Medi-Cal? | ____ | _____ |
| Is Patient Eligible for Other Government Programs? | ____ | _____ |

If eligibility exists for above programs, patient will not generally be eligible for charity care

| | | |
|---|---|---|
| Does Patient have other insurance (auto medpay, workers comp)? | ____ | _____ |
| Was Patient injured by third party? | ____ | _____ |
| Is Patient Self-Pay? | ____ | _____ |

Charity/Financial Assistance Calculation:

Total Family Income
(From Statement of Financial Condition) $_____

Family Size (From Statement of Financial Condition) _____

Qualification for Financial Assistance (Circle One) Full Partial

High Medical Cost

No Eligibility

**Exhibit E**

**NOTIFICATION FORM**

**ELIGIBILITY FOR CHARITY CARE**

St. Rose Hospital has conducted an eligibility determination for charity care for:

| _____ | _____ | _____ |
|---|---|---|
| PATIENT'S NAME | ACCOUNT NUMBER | DATES OF SERVICE |

The request for charity care was made by the patient or on behalf of the patient on _____.

The determination was completed on _____.

Based on information supplied by the patient or on behalf of the patient, the following determination has been made:

Your request for charity care has been approved for services rendered on _____.
After applying the charity care reduction, the amount owed is $_____.

Your request for charity care is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____
_____
_____
_____
_____

Your request for charity care has been denied because:

REASON:

_____
_____
_____
_____
_____
_____

Granting of charity care is conditioned on the completeness and accuracy of the information provided to the hospital. In the event the hospital discovers you were injured by another person, you have additional income, you have additional insurance or provided inaccurate information regarding your ability to pay for the services provided, the hospital may revoke its determination to grant charity care and hold you and/or third parties responsible for the hospital's charges. If you have any questions on this determination, please contact _____ at _____.

**Exhibit F**
**Important Billing Information for Patients at St. Rose Hospital**

Thank you for choosing St. Rose Hospital for your hospital services. The information below is designed to help you understand options available to assist patients pay their hospital bill. This information only applies to your hospital bill and does not include any bills received from physicians, anesthesiologists, clinical professionals, ambulance companies, etc., that may bill you separately for their services.

An emergency physician, as defined in California Health & Safety Code § 127450, who provides emergency medical services at St. Rose Hospital is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 % of the federal poverty level. You will receive a separate bill for the emergency physician services as well. Any questions pertaining to the emergency physician services should be directed to the physician providing the services as represented on the billing statement.

## Payment Options

St. Rose Hospital has many options to assist you with payment of your hospital bill.

Medi-Cal & Government Program Eligibility. You may be eligible for a government sponsored health benefit program. St. Rose Hospital has staff available to assist you with applying for government assistance like Medi-Cal, and California's Children Services to pay your hospital bill. St. Rose Hospital also contracts with a company that may assist you further, if needed.

Financial Assistance Program (Charity & Discount Care). Uninsured patients who have an inability to pay their bill may be eligible for financial assistance. Eligibility for financial assistance is based on income and family size. All potential payer sources must be exhausted before a patient is eligible for financial assistance. Copies of St. Rose Hospital's Financial Assistance Policy, applications for financial assistance, and applications for government programs are available at Patient Registration and our Patient Financial Services Office. We can also send you copies if you contact our Patient Advocate Specialist at 510-780-4342.

**If you have any questions, or if you would like to pay by telephone, please contact the Patient Advocate Specialist at 510-780-4342.**

**Exhibit G**

**NOTICE OF RIGHTS**

Thank you for selecting St. Rose Hospital for your recent services. Enclosed please find enclosed a statement the charges for your hospital visit. Payment is due immediately. Please be aware that this the bill for hospital services only. There may be additional charges for services that will be provided by physicians during your stay in the hospital such as bills from personal physicians and any anesthesiologists, pathologists, radiologists, ambulance companies or other medical professionals who are not employees of the hospital. You may receive a separate bill for these services.

An emergency physician, as defined in California Health & Safety Code § 127450, who provides emergency medical services at St. Rose Hospital is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 % of the federal poverty level. You will receive a separate bill for the emergency physician services as well. Any questions pertaining to the emergency physician services should be directed to the physician providing the services as represented on the billing statement.

Our records indicate that you do not have health insurance coverage or coverage under Medicare, Medi-Cal, Healthy Families, or other similar programs. If you have such coverage, please contact our Patient Accounts Financial Advocate at 510-780-4342 as soon as possible so the information can be obtained and the appropriate entity billed.

St. Rose Hospital has many options to assist you with payment of your hospital bill.

Medi-Cal & Government Program Eligibility. You may be eligible for a government sponsored health benefit program. St. Rose Hospital has staff available to assist you with applying for government assistance like Medi-Cal, and California's Children Services to pay your hospital bill. St. Rose Hospital also contracts with a company that may assist you further, if needed.

Financial Assistance Program (Charity Care). Uninsured patients who have an inability to pay their bill may be eligible for financial assistance. Eligibility for financial assistance is based on income and family size. All potential payer sources must be exhausted before a patient is eligible for financial assistance. Copies of St. Rose Hospital's Financial Assistance Policy, applications for financial assistance, and applications for government programs are available at Patient Registration and our Patient Financial Services Office. We can also send you copies if you contact our Patient Advocate at Specialist at 510-780-4342.

**If you have any questions, or if you would like to pay by telephone, please contact the Patient Advocate Specialist at 510-780-4342.**

**Exhibit H**

**NOTICE LANGUAGE ON BILLS FOR UNINSURED PATIENTS**

Our records indicate that you do not have health insurance or coverage under Medicare, Medi-Cal, or similar other programs. Patients who lack insurance and meet certain income requirement may qualify for financial assistance. Please contact the Patient Advocate Specialist at 510-780-4342 to obtain further information.