LOS ANGELES COUNTY - DEPARTMENT OF HEALTH SERVICES
OSHPD AB 774 Requirements• Hospital Application Forms

OSHPD Requirement	Los Angeles County Armlication Form
1) Charity Care	Ability-to-Pay (ATP) Services Agreement
2) Discount Payment Policy	Ability-to-Pay (ATP) Services Agreement intended for LA County Residents Discount Payment Plan Agreement intended for non-LA County Residents. Also intended for LA County Residents for non-medically necessary cosmetic surgery and infertility related care, which is not covered by ATP.

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
ABILITY-TO-PAY (ATP) PLAN SERVICES AGREEMENT

Facility:_____ MRUN#_____ Date: _____

SECTION I: PATIENT INFORMATION

Patient_____ DOB:_____ Social Security#:_____

Address: City: State:____ Zip:____

Telephone: [Home] _,_____ Work] _,_____ [Message] -"------

Los Angeles County Resident D Yes D No {Ineligible) Patient has approved Restricted Medi-Cal o Yes □ No

SECTION II: INCOME INFORMATION

Family members in patient's household ____ _ Total Monthly Income

(From Worksheet Part B, Line 1)

SECTION III: ATP LIABILITY

In consideration for being charged for health care services rendered by the County of Los Angeles (County) to the patient in accordance with the County's Ability-to-Pay Plan (ATP), I/we (patient or responsible relative) ——— ————————" promise to pay the County for services received from the County's health care facilities, from _____ through _____ ,th ATP Liability Amount of:

_____ dollars ($_____ per admission for all inpatient services provided to the patient covered by this Agreement from admission until discharge from the County's Health care facility;
AND
- -dollars ($ - —— f each month during which outpatient services are received by the patient covered by this Agreement for all outpatient visits provided during that month.

SECTION IV: ATP CERTIFICATION

Such ATP Liability Amount has been determined under the ATP and is based upon information which I/we provide in this Agreement. I/we understand that I/we may be asked later for proof of some or all of the information used for this Agreement. I understand that I am expected to save documents I might have that would help prove that what I said today is true, (for example, copies of pay stubs, income tax returns, bank statements, receipts), for 6 months from the date of the application. If I am asked for these documents in the next 6 months, I will have 20 days to mall or bring the information to the facility or to give some other acceptable verification. If I am asked for this proof and don't provide it, I may be held responsible for the full charges for my medical care.

It is understood and agreed that the above ATP Liability Amount for such inpatient services or for such outpatient services shall not be subsequently adjusted for any reason except as provided under the ATP.

I/we understand and agree that this Agreement shall be governed by the terms and conditions set forth in the ATP, which has been made available to me/us for review and which is incorporated herein by reference, and that I/we shall fully cooperate with the County in accordance with the ATP. Pursuant to Section 360.5 of the California Code of Civil Procedure, I/we agree that all statutes of limitation upon the debt for the health care services which are covered by the Agreement are hereby waived.

I/we certify that, during the next year, if the patient gets or loses insurance, or if his or her family size or income changes, I/we promise to immediately report that fact to the facility where this form was completed.

It is agreed that if I/we have a change in financial circumstances, including but not limited to an increase in the patient's or guarantor's income, or the patient, or patient's heirs or personal representative(s), receipt of damages recovered as a result of patient's injury by accident, negligence, or wrongful act, I/we will notify the facility where this Agreement was completed and this Agreement may, at the election of the County of Los Angeles, be terminated, and the County's hospital shall be entitled to its reasonable charges.

This agreement shall not in any way diminish or defeat the County's right, under the California Government Code sections 23004.1 and 23004.2, or the Hospital Lien Act, or any other applicable laws to recover reimbursement from any responsible third-parties, including tortfeasors, the reasonable charges for health care services provided to the patient.

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
ABILITY-TO-PAY (ATP) PLAN SERVICES AGREEMENT

I/WE CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE PROVIDED AS PART OF THE APPLICATION PROCESS AND AS LISTED ABOVE IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY BY MY/OUR SIGNATURES THAT I/WE HAVE READ AND UNDERSTAND ALL THE FORGOING AND THAT I/WE AGREE TO SIGN THIS STATEMENT WITHOUT ANY RESERVATION WHATSOEVER.

Signature	Date	**Responsible Relative Signature**	**Date**
Interviewer Signature	Date	**Responsible Relative Signature**	**Date**
		Supervisor's Approval	Date

Sdavda\Final FP 520.15 Exhibit 111122914

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

DISCOUNT PAYMENT PLAN AGREEMENT (INPATIENT/OUTPATIENT)•

(Please Print)

Facility: MRUN# Inpt. Admit Date Outpt. Date

SECTION I: PATIENT INFORMATION

Patient DOB: Social Security#:

Permanent Address: City: Country/State/County: Zip:

Telephone: [Home] ----------{Work} --------- [Message] --------- -

Local Address:

SECTION II: INCOME INFORMATION:

Family size

Grand Total Monthly Gross Income - [Enter from Worksheet, Part A. 4 or E. 3} <r::

DISCOUNT PAYMENT PLAN ELIGIBILITY: (County Use Only)

Family income less than or equal to 350% FPL:

D Yes (eligible) ☐ No (ineligible)

SECTION III: DISCOUNT PAYMENT PLAN CERTIFICATION:

t certify that, as of today's date, I, {or patient), do/(does) not have Medi-Cal, Medicare, Short Doyle, CHAMPUS, California Children Services, or private health insurance, or any other form of health care coverage for the condition for which the patient is being treated.

In consideration for being charged for health care services rendered by the County of Los Angeles (County) in accordance with the County's Discount Payment Plan, 1/we ---------- romise to pay the County (check one):

D INPATIENT: For aH inpatient services received by the patient covered by this Agreement from admit date of unlil discharged from the County's Health care facility, the Discount Payment Plan Liability Amount of - - - - - - dollars ($, per day for such inpatient stay of admission or 95% of the patient liable amount for person with healt7h care coverage (except Medi-Cal beneficiaries with a share of cost), whichever is less; or for persons without health care coverage and Medi-Cal beneficiaries with a share ofcost, $" per day for such inpatient stay of admission or 95% of gross charges, whichever is less OR

D OUTPATIENT: For all outpatient services received by the patient covered by this Agreement from--------"--- through ———— the Discount Payment Plan Liability Amount of dollars ($ for each outpatient visit during such period or 95% of the patient liable amount for person with health care coverage (except Medi-Cal beneficiaries with a share of cost) or for persons without health care coverage and Medi-Cal beneficiaries with a share of cost), $ for each outpatient visit during such period or 95% of gross charges, whichever is less.

Pursuant to Section 360.5 of the California Code of Civil Procedure, which allows written waivers related to actions for the repayment of County aid, I/we hereby waive all statues of limitation upon collection of debt covered by this Agreement.

I/we certify that, during the next year, if the patient gets or loses insurance, or if his or her family size or income changes, I/we promise to immediately report that fact to the facility where this form was completed.

It is agreed that if I/we have a change in financial circumstances, including but not limited to an increase in the patient's or guarantor's income, or the patient, or patient's heirs or personal representative(s), receipt of damages recovered as a result of patient's injury by accident, negligence, or wrongful act, I/we will notify the facility where this Agreement was completed and this Agreement may, at the election of the County of Los Angeles, be terminated, and the County's hospital shall be entitled to its reasonable charges.

This agreement shall not in any way diminish or defeat the County's right, under California Government Code Sections 23004.1 and 23004.2, or the Hospital Lien Act, or any other applicable laws to recover reimbursement from any responsible third-parties, including tortfeasors, the reasonable charges for health care services provided to the patient.

I/WE CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE($) THAT THE INFORMATION I/WE HAVE PROVIDED AS REQUESTED IN THIS AGREEMENT IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY BY MY/OUR SIGNATURES(S) THAT I/WE HAVE READ AND UNDERST AN☐ ALL THE FOREGOING AND THAT I/WE AGREE TO SIGN THIS STATEMENT WITHOUT ANY RESERVATION WHATSOEVER.

Patient/Responsible Relative Signature: Date:

County Interviewer: {Print Name) Telephone No.: ——————

{Signature) Date:"-------

(Supervisor's Signature) Date:"

Check box, if applicable:

Patient not eligible for Medi-Cal/Medicaid.

* Discount Payment Plan Agreement intended for non-LA County Residents. Also intended for LA County Residents for non-medically necessary cosmetic surgery and infertility related care, which is not covered by ATP, or who are Medi-Cal beneficiaries with high medical costs or persons with health care applications pending.