CHILDREN'S HOSPIAL & RESEARCH CENTER AT OAKLAND
COMMUNITY CARE APPLICATION INSTRUCTION

Instructions

As part of our commitment to serve the community, Children's Hospital & Research Center at Oakland, provides financial assistance to patients/guarantors who are not eligible for State or Federal programs, uninsured or underinsured. This program is Community Care.

To determine if a patient/guarantor qualifies for Community Care, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please provide the following information and copies of information with your financial assistance application:

1. Statement of Financial Condition
2. Documents to verify income:

Please provide one or more of the following:	**Please provide a copy of one of the following:**
A. IRS Form W-2, Wage and Earnings	A. Government Assistance, Social Security or Workers' Compensation; or
B. Last two pay check stubs for all household earnings; and/or	B. Unemployment compensation letter; or
C. Bank statement that contains income information.	C. Income tax return for previous year.

In the event income verification that is unavailable, please contact our office for further instructions. Applications without income verification are considered incomplete and will not be processed. For assistance in completing this application, please contact Children's Hospital & Research Center at Oakland (510) 428-3485. Monday through Friday from 8:00 a.m. to 4:00 p.m. Please return the application and verification of income documents within 14 calendar days to

Patient Accounting Office-Community Care
Children's Hospital & Research Center at Oakland
3271 Adeline Street
Berkeley, CA 94703

We will notify you of your eligibility following receipt and review of all necessary information. The notification will be mailed to the mailing address you have provided on the Community Care Application

Children's Hospital & Research Center at Oakland
Community Care Program
STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____ **ACCOUNT NO:** _____
GUARANTOR NAME _____
GUARANTOR NAME _____
ADDRESS _____
_____

Phone _____

FAMILY STATUS: List all dependents in the household

Name:	**Age**	**Relationship**
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

EMPLOYEMENT AND OCCUPATION

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

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

CURRENT MONTHLY INCOME

		Guarantor	**Guarantor**
	Gross Pay (Before deduction)	_____	_____
Add	Income from Operating Business (if Self-Employed)	_____	_____
Add	Other Income:		
	Interest and Dividends	_____	_____
	From Real estate or Personal Property	_____	_____
	Social Security	_____	_____
	Other (specify)	_____	_____
	Alimony or Support Payments Received	_____	_____
Subtract	Alimony, Support Payments Paid	_____	_____
Equals	Current Monthly Income	_____	_____
Total Monthly Income (Combine both Guarantors)		_____	_____

FAMILY SIZE

Total Family Members: (Add patient, guarantors and dependents form above) _____

By signing this form. I agree to allow Children's Hospital & Research Center at Oakland to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I am also required to provide the documents outlined in the Children's Financial Assistance Application Instructions within 14 days.

_____ _____

Signature of Guarantor Date

_____ _____

Signature of Guarantor Date

(Internal Document for screening)

Date:_____

COMMUNITY CARE ASSISTANCE SCREENING WORKSHEET

Patient Name : _____
Account Number(s) : _____

Special Consideration/Circumstances:

_____

_____

	Yes	No
Does patient have insurance?	☐	☐
Have you applied for Medi - Cal?	☐	☐
Is patient eligible for other Government Programs?	☐	☐
Is patient self-pay?	☐	☐

Community Care Assistance Calculation

Total Combined Current Monthly Income $_____

Total Annual Income $_____

Family Size _____

Total Medical Expenses Liability $_____

Community Care Discount

Review total number in household and annual income, review chart below to determine eligible discount.

Total Discount approved _____%

Number is Household	Up to 300% of FPL	Up to 400% of FPL	Up to 500% of FPL
1	$32,490	$43,320	$54,150
2	$43,710	$58,280	$72,850
3	$54,930	$73,240	$91,550
4	$66,150	$88,200	$110,250
5	$77,370	$103,160	$128,950
6	$88,590	$118,120	$148,650
7	$99,810	$133,080	$166,350
8	$111,030	$148,040	$185,050
Discount	100%	75%	50%

Date:_____ Signature of Financial Counselor:_____