CITY AND COUNTY OF SAN FRANCISCO
Gavin Newsom, Mayor

DEPARTMENT OF PUBLIC HEALTH
Mitch Katz, Director

Laguna Honda Hospital

LHH CHARITY CARE AND DISCOUNT PAYMENT PROGRAMS

APPLICATION

APPLICANTS MUST MEET THE FOLLOWING CRITERIA TO BE CONSIDERED FOR ELIGIBILITY TO THE CHARITY CARE OR DISCOUNT PAYMENT PROGRAMS:

- Must Not be eligible for government / non-government payers or Have high medical expenses/costs
- Must apply for services received at Laguna Honda Hospital
- Must apply for services that have not already been discounted
- Must have a gross family household income at or below 350% federal poverty level
- Must provide most recent quarter's pay stubs or most recent year tax return statement
- Must provide verification of qualified liquid assets for Charity Care consideration
- Must provide verification of high paid medical expenses in the past 12 months or have high SFGH medical expenses for Discount Payment consideration

INSTRUCTIONS FOR APPLYING:

- Patient or Representative must complete and sign this application
- Submit your application and verification documents by:
    - Mail your application and verification documents or drop in to apply at:

      Laguna Honda Hospital
      Admitting & Eligibility Department
      375 Laguna Honda Blvd. UnitC-5
      San Francisco, CA. 94116
- Call (415) 759-4566 for detailed information

Date of Initial Contact _____
Requested by _____

APPLICANT INFORMATION

Last name:	First name:
Date of Birth:	Medical Record #:

PERMANENT ADDRESS

Address:	City:
State:	Zip Code:
Country:	Telephone:
Cell phone:	Email:

ELIGIBILITY & SCREENING

What is your marital status?	☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Domestic Partner
Do you have medical insurance?	☐ Yes ☐ No ***If yes, specify:*** ***Provide insurance card.***
Do you have a disability expected to last 12 months?	☐ Yes ☐ No
Do you have a pending application with Medi-Cal?	☐ Yes ☐ No
Were you pregnant on of service?	☐ Yes ☐ No
Family Size (self, spouse and children under 21 yrs old)	# _____
Source of Income (GA, unemployment, Social Security, Pension	$ _____
Total assets on date of service: *Excluding retirement and deferred compensation plans:*	$ _____ ***Provide financial statements most recent quarter (3 mos.) to date of service.***
Any real estate in which patient is not living?	☐ Yes ☐ No
TPL/Injury/Assault: Circumstance of injury _____ TPL ☐ Yes ☐ No Work Related ☐ Yes ☐ No	
Auto Insurance _____	

I declare the answers given are true and correct to the best of my knowledge. I understand the information provided will be used to screen for eligibility to various Federal, State and County Programs. I understand that if information is found to be false, I will be held responsible for the full amount of any fees for medical services received from Laguna Honda Hospital.

APPLICANT SIGNATURE *DATE*

DEPARTMENT USE ONLY FOR ELIGIBILITY REVIEW

Charity Program ☐ Eligible ☐ Ineligible

Discount Program ☐ Eligible ☐ Ineligible

Denial Reasons:

- ☐ Non-compliance
- ☐ Insured by government or non-government payer
- ☐ Services were not received at LHH
- ☐ Other (specify)_____
- ☐ Income over 350% FPL
- ☐ No high medical costs
- ☐ Services received are already discounted

Print Name:

Signature:

Date:

APPEALS PROCESS FOR DENIED APPLICATIONS

If you have been determined ineligible for the Charity Care and Discount Payment programs and wish to appeal your denial for eligibility, you have **15 business days** to appeal from the date of your eligibility determination. Please submit a copy of this completed application with your written statement below of the reason for your appeal request to:

Laguna Honda Hospital, 375 Laguna Honda Blvd., San Francisco, CA 94116
Attention: _____, Eligibility Manager

Reason for appeal request:

APPEALS DECISION

Charity Program	☐ Eligible ☐ Ineligible
Discount Program	☐ Eligible ☐ Ineligible
Decision made by:	
Print Name:	
Signature:	
Date:	