EXHIBIT A

CHARITY CARE REQUEST FORM

1. WHAT IS YOUR CURRENT ADDRESS? ____________________
____
2. TELEPHONE NUMBER? __________
3. ARE YOU BUYING OR RENTING YOUR HOME? __________
4. WHAT IS YOUR SPOUSES NAME? ____________________
5. HOW MANY CHILDREN, LIVING AT HOME UNDER THE AGE OF 18? __________
6. DO YOU RECEIVE CHILD SUPPORT? __________
7. DO YOU PAY CHILD SUPPORT? _____ HOW MUCH? __________
IS IT PAID VOLUNTARILY OR ATTACHED TO YOU WAGES? __________
8. WHO IS YOUR CURRENT EMPLOYER? ____________________
HOW LONG? __________ POSITION HELD? ____________________
FULL OR PART-TIME? ________ WHEN ARE YOU PAYDAYS? __________
DO YOU RECEIVE COMMISSIONS OR BONUSES? __________
9. WHAT IS YOUR MONTHLY INCOME BEFORE TAXES? __________
10. IF SPOUSE IS EMPLOYED – EMPLOYER'S NAME: __________
11. WHAT IS YOUR COMBINED MONTHLY INCOME BEFORE TAXES? __________
12. MONTHLY PAYMENTS?
HOME: __________
FIRST VEHICLE: __________
SECOND VEHICLE: __________
BOAT/CAMPER/RV: __________
PG&E: __________
CREDIT CARDS: __________
OTHER (PLEASE LIST):
____
____
____
____
____
____

____________________ ____________________
SIGNATURE DATE

EXHIBIT A

Patient Request for Discount Eligibility

1. Patient's name: ______________________
2. Current address: ______________________
3. Phone number: ______________________
4. Date(s) of service at the hospital: ______________________
5. Inpatient or Outpatient: ______________________
6. Primary health insurance: ______________________
7. Number of people in your family: ______________________
8. Current employer: ______________________
9. Estimated family gross annual income: ______________________
10. Estimated family annual out-of-pocket medical costs: ______________________

______________________ SIGNATURE

______________________ DATE

EXHIBIT B

Financial Screening Assessment

1. Patient's name: ______________________
2. Current address: ______________________
3. Phone number: ______________________
4. Date(s) of service at the hospital: ______________________
5. Inpatient or Outpatient: ______________________
6. Primary health insurance: ______________________
7. Total billed charges on account: ______________________
8. Payment received from primary payor: ______________________ (A)
9. Allowance due to contractual agreement with primary payor: ______________________

Continue only of there is no contractual allowance, otherwise not eligible

10. Verified number of people in your family: ______________________

    i) How documented or confirmed? ______________________

    ii) 200% of Poverty Level for family size: ______________________ (B)

11. Current employer: ______________________
12. Verified family gross annual income: ______________________ (C)

    i) Confirmed by pay-stubs or tax return? ______________________

Continue only if "C" is less than "B", otherwise not eligible for discount

13. Verified family annual out-of-pocket medical costs: ______________________ (D)

    i) How documented or confirmed? ______________________

ii) Medical Costs (D) / Income (C) % ______________________

Continue if "D" divided by "C" is greater than 10%, otherwise not eligible

14. Patient balance after primary insurance: ______________________ (E)

15. Expected Medicare payment for service: ______________________ (F)

16. Which is greater? – The payment received (A)
or Medicare payment for this service (F): ______________________

If "A" is greater than "F", patient is eligible for discount allowance of entire balance due after primary payor has paid.

If "F" is greater than "A", patient is responsbible for paying the difference between the payment received from primary payor, and the expected payment from Medicare for the same service. A discount will be allowed to reduce the Patient Balance Due (E) to the difference between "A" and "F".

17. DISCOUNT allowed by this policy: ______________________ (G)

18. Adjusted balance due ("E" minus "G"): ______________________

If adjusted balance due from patient is less than $1,200, patient may elect to pay this over a maximum of 12 monthly payments, interest free.
If balance due is greater than $1,200, patient may elect to make payments of <u>at least</u> $100 per month until balance is paid in full, interest free.

19. Monthly payment agreed to: ______________________

19. How many months to pay off balance? ______________________

______________________ ____________
Collection Representative Date

______________________ ____________
Patient Date

______________________ ____________
Business Office Manager or CFO Date