SAN GABRIEL VALLEY MEDICAL CENTER, AHMC

AHMC Confidential Medical and Financial Assistance Application

Facility: **ARMC**	Acct. #:	Patient Name:	SSN:	DOB:
Patient Address:				
Patient Home Phone:		Patient Work Phone: None		

SECTION A

MEDICAL ASSISTANCE SCREENING– *Please check answer "Y" for yes to "N" for no.*

	Y / N		Y / N
1. Is the patient under age 21 or over age 65?	/	5. Is the patient pregnant, or was the admission pregnancy related?	/
2. Is the patient a single parent of a child under age 21?	/	6 Will the patient potentially be disabled for 12 months?	/
3. Is the patient a caretaker or guardian of a child under 21?	/	7. Is the patient a Victim of Crime?	/
4. Is the patient a married parent of a minor child? *If yes, does the patient have a 30-day incapacitation?*	/	8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed?	/

SECTION B

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:		Relationship to patient:
SSN:	DOB:	
Home Address:		Phone #:
Work Address:		Phone #:
Gross Income:	Circle One - ☐ Hourly ☐ Daily Weekly Bi-Weekly ☐ Monthly ☐ Yearly	
	Hours Per Week:	
If income is $0/unemployed, what is your means of support?	☐ Living on Savings/Annuity ☐ Live with parent/family/friends Homeless ☐ Shelter ☐ Deceased ☐ Other:	

SPOUSE

Responsibility Party:		
SSN:	DOB:	
Home Address:		Phone #:
Work Address:		Phone #:
Gross Income**:**	Circle One - ☐ Hourly ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	
	Hours Per Week:	

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SECTION C

HOMELESS AFFIDAVIT

I, herby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others. _____

Patient/Guarantor Initials

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in the denial of this Application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services maybe considered an unlawful act. I also acknowledge and consent that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that AHMC Charity Care program(s) is a "Payor of Last Resort" and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for fitness or injury, for which AHMC or its' subsidiaries provided care.

_____ _____

PATIENT/GUARANTOR SIGNATURE **DATE**

SECTION D

FINANCIAL ASSISTANCE SCREENING

Total Number of Dependent Family Members in Household __

(Include patient, patient's spouse and/legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father and/or legal guardian, and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income $ **0.00**

Calculate Income to FPG Ratio: $____

Gross Annual Income ÷ FPG Based on Family Size: ____ **%**

Type of Service Check One **ER** ☐ **OP** ☐ **IP** ☐ **MULTI** ☐

Total Co-pay Amount Due: $____

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SECTION E

OFFICE USE ONLY

Family Size:	1	Acct Number(s) / Branch	Pt Type / Date of Service	Balance	W/O Amount	Co-Pay
Gross Annual Family Income:	$				$	$
FPG based on Family Size:	$					$
Current Hospital Charges (w/ in 6 months):	$			$	$	$
Income/FPG:	%			$	$	$
Income X 2:	$			$	$	$
Total Hospital Charges:	$					

Prepared by _____ Date _____ Unit _____

Examined by _____ Date _____ Unit _____

_____

Approved or Denied by _____ Date _____ Title _____

Denial Reason: