NIH
People you know, caring for people you love

INYO HOSPITAL
Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
(760)873-2190 voice
(760)873-2115 fax

***ATTENTION:* Before you submit your application, review and assure you have *checked off* and *attached* the necessary documents listed below.**

DOCUMENTS NEEDED

Check Off:

- ☐ _____ Tax Return, W2's or Letter of Extension Filed.
- ☐ Social Security Award Letter for Current Year _____.
- ☐ 2 Months Pay Stubs for all Employment.
- ☐ 3 Months Bank Statements for all Bank Accounts, i.e.: Checking, Savings, IRA, Deferred Retirement, Money Markets, Certificate of Deposits, Investments.
- ☐ Copy of Insurance/Medi-Cal Cards.

Additional Information may be Required as you go thru the Application Below.
SUCH AS:

- ☐ School Letter *if applicable.*
- ☐ No Income Letter *if applicable.*
- ☐ Letter from Employer stating no Insurance offered.
- ☐ Amount of Insurance Premiums from Employer Offered Health Plan.
- ☐ Purchased Private Health Plan on CoveredCA.Com.
- ☐ Notice of Action Medi-Cal, All Members in Family.
- ☐ Medi-Cal Insurance Cards, All Members in Family.
- ☐ Include a copy of your driver's license, other photo ID or documents that verify your current residence.
- ☐ Signed authorization release from Medi-Cal Office.

CHARITY CARE APPLICATION

Does not cover routine tests. It is limited to medical necessity ONLY.

Name: Last	First	M.I.	AKA:	Date of Birth:

Social Security Number:	Employer:	Employer Telephone:

Spouse Name: Last	First	M.I.	AKA:	Date of Birth:

Spouse Social Security:	Spouse Employer:	Spouse Employer Telephone:

Address:	Telephone:
Physical:	Home:
Mailing:	Cell:

1. FAMILY INFORMATION

If applicable, please list the applicant's children under 18 who live with the applicant or other family members. This section can be left blank if the applicant does not live with children or other family members. When including total number of family members include spouse or significant other (if you share children in common)

If child is **over 18** and a full time student and has no source of income, please provide a letter from the school showing enrollment.

Name of family member	Relationship	Date of birth
	Total Family Members:	

DOCUMENTATION REQUIRED:

ATTACH documentation that verifies the income listed above: last two month's pay stubs (minimum 4), income taxes, W2 statements, last three month's bank statements or other proof.
ATTACH other required documentation as applicable throughout application:
School Letter
No Income Letter

2. EARNED INCOME

Please complete this section about earned income for the applicant, spouse and each household member listed in section 1 who works. **Please list gross income, which is income before taxes and deductions.**

Working family member name	Employer name and address	Gross Earnings	How often *check one*	COMMENTS
			☐ Weekly ☐ Monthly ☐ Yearly	
			☐ Weekly ☐ Monthly ☐ Yearly	
			☐ Weekly ☐ Monthly ☐ Yearly	
			TOTAL:	

3. OTHER INCOME

Please complete this section about other income for the applicant, spouse and each household member listed in section 1. **Please list gross income, which is income before taxes and deductions.** If you do not have these income sources, complete with a zero. Please attach supporting documents.

Type of income	**Family member(s) receiving income**	**Gross Received**	**How often** *check one*	**COMMENTS**
Unemployment			☐ Weekly ☐ Monthly ☐ Yearly	
Social Security			☐ Weekly ☐ Monthly ☐ Yearly	
Veteran's Benefits			☐ Weekly ☐ Monthly ☐ Yearly	
Annuities and Pensions			☐ Weekly ☐ Monthly ☐ Yearly	
Child Support & Alimony			☐ Weekly ☐ Monthly ☐ Yearly	
Rental Income			☐ Weekly ☐ Monthly ☐ Yearly	
Workers Comp			☐ Weekly ☐ Monthly ☐ Yearly	
Dividend & Interest Income			☐ Weekly ☐ Monthly ☐ Yearly	
Checking Balance			☐ Weekly ☐ Monthly ☐ Yearly	
Savings balance			☐ Weekly ☐ Monthly ☐ Yearly	
Other – List:			☐ Weekly ☐ Monthly ☐ Yearly	
	TOTAL:			

Grand Total Earned and Other Income:	
If the household income is zero, please attach a letter from individual (s) who are supporting you or a letter yourself describing how you are	

supporting yourself signed and dated.	

Before submitting, please make sure that you have completed all applicable sections of this application and <u>have included all requested documents</u> (anything submitted must include your name) to verify your financial status. Incomplete applications will not be approved.

I certify that the above information is true and accurate to the best of my knowledge. **Further, I will make application for any assistance (Medicaid, MediCal, Healthy Families, Medicare, <u>including open enrollment – November 1st – for Covered California; Initial Acknowledgment</u> _____*, Insurance, etc.) which may be available for payment of my hospital or clinic charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital or clinic charges.** ****My initials above indicate my acknowledgment and understanding of my obligation to make application for coverage.*** *(**Failure to comply with timely application for such assistance or failure to complete application may be a basis for denial of requested uncompensated services.)* If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Date of Request_____ Applicant's Signature_____

If you have been denied and would like to appeal the decision, please contact the Revenue Cycle Director at the above address or by telephone at (760) 873-2185.