Huntington Hospital

Huntington Hospital Financial Assistance/Charity Care Application

Please fill out all of the information completely

Disclaimer

We cannot guarantee that you will qualify, even if you apply. A written response will be provided to all patients supporting approval/denial after we receive your completed application and documentation. The Financial Assistance Policy covers medically necessary care provided at Huntington Hospital. Elective cosmetic services and any other providers of service except Huntington Hospital are not covered under this program.

FAILURE TO SUPPLY ALL REQUIRED INFORMATION WILL RESULT IN DENIAL.

Screening Questions

Does the patient have health insurance?	☐ **Yes**	☐ **No**
Has the patient applied for Medi-Cal/Welfare Public Assistance?	☐ **Yes**	☐ **No** **If YES, which one?**
Is the patient currently homeless?	☐ **Yes**	☐ **No**
Is the patient currently employed?	☐ **Yes**	☐ **No**
Is the patient's medical care related to a car accident or a work injury?	☐ **Yes**	☐ **No**

Patient Information

Patient Account #:	**Statement #:**	
Patient Last Name:	**Patient First Name:**	**Patient Middle Name:**
Patient Date of Birth:	**Social Security Number:**	☐ **Male** ☐ **Female**

Guarantor / Responsible payer Information

Person Responsible for Paying Bill:	**Relationship to Patient:**	**Date of Birth:**	**Social Security Number:**
Mailing Address: _____ _____ **City** **State** **Zip Code**			**Contact Information:** ***Home*** **:** _____ ***Cell:*** _____ ***Email*** **:** _____

Employment status of person responsible for paying bill: ☐ **Employed** ☐ **Unemployed** ☐ **Self Employed**

☐ **Retired** ☐ **Student** ☐ **Disabled** ☐ **Other:** _____

Spouse / Domestic Partner Information

Spouse Last Name:	**Spouse First Name:**	**Spouse Middle Name:**
Spouse Date of Birth:	**Spouse Social Security Number:**	☐ **Male** ☐ **Female**
Spouse Mailing Address (if different from Patient): _____ _____ **City** **State** **Zip Code**		**Spouse Contact Information:** ***Home*** **:** _____ ***Cell:*** _____ ***Email*** **:** _____

Spouse Employment Status: ☐ **Employed** ☐ **Unemployed** ☐ **Self Employed** ☐ **Retired**

☐ **Student** ☐ **Disabled** ☐ **Other:** _____

Family Information

Please list the family members in your household, including yourself. You must be able to provide proof of the number of people you support in your Federal Tax Returns. Family includes anyone related by birth, marriage, or adoption who live with you. If the family member is 18 years or older, please answer columns 4 and 5 below. ***Examples of sources of income include: Wages, Self-Employment, Unemployment, Disability, Child/Spousal Support, Pension, SSI, Work Study Programs (students), Retirement Accounts, etc.***

 # OF PEOPLE IN FAMILY: _____

1. Name:	2. Date of Birth:	3. Relationship to Patient:	4. Employer Name/Source of Income:	5. Total Gross Monthly Income (before taxes):	6. Minor Also Applying for Financial Assistance? (separate application needs to be completed)
					☐Yes ☐ No Account # _____
					☐Yes ☐ No Account # _____
					☐Yes ☐ No Account # _____
					☐Yes ☐ No Account # _____
					☐Yes ☐ No Account # _____
					☐Yes ☐ No Account # _____

If you need to enter additional family members, please attach an another page

Huntington Hospital Financial Assistance/Charity Care Form - *Continued*

Income Information - PROOF REQUIRED

You must provide the following information about your family's income. Income verification is required to determine financial assistance. All family members 18 years or older must provide their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income:

YOU MUST PROVIDE THE FOLLOWING INFORMATION:

1) Previous year's income tax return (Complete Tax Report)

2) Current paycheck stubs for the last 2 months (Self/Spouse/ Domestic Partner if applicable) if unable to supply paycheck stubs, you are required to provide 2 months of bank statements.

3) Letter of hardship (Description supporting your financial needs)

If you are unable to provide your tax return information due to delay in tax filing, temporary disability or unemployment, please provide your non-filing tax form and the last 2 months of your bank account statements.** ***You can obtain a copy by calling 1-800-908-9946 or visit www.irs.gov/individuals/get-transcript (use form 4506-T or 4506T-EZ)

*** Permanently Disabled/Retired applicants need to provide a copy of their Social Security Award Letter. (If not available please provide last 2 months of your bank account statements).**

*** If you are a student on financial aid, please provide a copy or letter of approval of your school financial aid and/or student loan information with your application.**

***Upon receipt of application, a credit report will be processed (will include spouse).**

Expense Information

In circumstances where you qualify for partial financial assistance, providing the information below will help establish a reasonable payment plan for the remainder of your balance.

Please enter your MONTHLY expenses:

Rent/Mortgage: $ _____
Insurance Premiums: $ _____
Other Debt/Expenses: $ _____
Medical/ Dental Expenses: $ _____
Childcare/School: $ _____
Groceries: $ _____
Utilities: $ _____
Child/Spousal Support: $ _____
Transportation/Car: $ _____
Clothing/Other Misc. $ _____

Sources of Income/Asset Information

What are your sources of income? Please specify monthly or yearly for all that apply.

	Monthly	Yearly		Monthly	Yearly
Job Income:	**$ _____**	**$_____**	**Interest/Dividend Income:**	**$ _____**	**$_____**
Spouse Job Income :	**$ _____**	**$_____**	**Social Security Income:**	**$ _____**	**$_____**
Business Income:	**$ _____**	**$_____**	**Alimony/Support Income:**	**$ _____**	**$_____**
Rental Income:	**$ _____**	**$_____**	**Other Income:**	**$ _____**	**$_____**

Total Income: $ _____
Current Checking Account Balance: $ _____
Current Savings Account Balance: $ _____

Does your family have other assets? Please check all that apply:

☐ **Stocks** ☐ **Bonds** ☐ **401K** ☐ **Health Savings Account(s)** ☐ **Trust(s)**

☐ **Property (including primary residence)** ☐ **Own a Business**

Patient Agreement

I understand Huntington Hospital may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.
I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services rendered. FAILURE TO SUPPLY ALL REQUIRED INFORMATION WITHIN 10 DAYS WILL RESULT IN DENIAL.

_____ _____
Signature of Person Applying for Financial Assistance **Date**

Financial Assistance Policy Summary

Huntington Hospital is dedicated to making healthcare services accessible to our patients and acknowledges the financial needs of our community who are unable to afford the charges associated with the cost of their medical care. Huntington Hospital provides Financial Assistance for qualifying patients who receive emergency or medically necessary care. Patients must complete an application, submit verification documents and meet the eligibility requirements listed below. This policy does not cover any other providers of service except Huntington Hospital.

Who is eligible for financial assistance?

Our program helps low-income, uninsured or underinsured patients who need help paying for all or part of their medical care. Patients are eligible for Financial Assistance when their family income is at or below 350% of the Federal Poverty Guidelines (FPG). Additional information may be requested and ultimately may affect the hospital's decision.

Patients who are eligible for Financial Assistance will not be charged more than amounts generally billed (AGB) for emergency or other medically necessary care to patients with insurance. (AGB as defined by IRS Section 501(r)). See appendix A in Financial Assistance Policy.

What does the program cover?

The Financial Assistance program covers medically necessary care provided at Huntington Hospital. **Elective cosmetic services are not covered under this policy.**

What will I need to provide to submit an application?

1) Previous year's income tax return (**complete tax report**)

2) Current paycheck stubs for the last 2 months (Self/Spouse/ Domestic Partner if applicable) if unable to supply paycheck stubs, you are required to provide 2 months of bank statements.

3) Letter of hardship (Description supporting your financial needs).

You must provide information about your family's income. Income verification is required to determine financial assistance. All family members 18 years or older in the household must provide their income. **There are detailed explanations on the financial assistance application.**

Who can I contact if I have questions filling out the application?

For Assistance on completing the application or to request a copy of the application policy Summary you may receive help at any of the following sources:

- Call the business office at (626) 397-5324 between the hours 8:30am to 4:00PM M-F, messages left after hours will be returned within 24 hours.
- By mail at the address listed below
- Download an application and copy of Summary policy at **https://www.huntingtonhospital.org/Targeted-Search.aspx?C=financial%20assistance#~75H8i71**

Is there language assistance available?

The policy and application forms are available in most languages spoken in our community and are available at the above mentioned locations. Interpreter services are also available.

Huntington Hospital
100 W. California Blvd.
PO Box 845656 Los Angeles, CA 90084-5656
Attention: Business Office