	Mission Community Hospital POLICIES & PROCEDURES	Index: LD Page 1of 6 Approval:
TITLE: **Charity** Care **and Discount Care Policy**		
Effective Date: 1/1/2015 , **Reviewed Date: 11/26/14**		
Revised Date: June 2003; July 2008; January 2015; January 2016		

1. Purpose. To establish a formal process whereby Deanco Healthcare LLC, doing business as Mission Community Hospital ("MCH"), provides charity care in compliance with California Health and Safety Code Section 127400 et seq.

2. Policy. MCH provides Charity Care and Discount Care as part of its commitment to provide high quality health care services efficiently and in support of human dignity and wellness, regardless of a patient's ability to pay. Charity Care and Discount Care are not considered to be a substitute for personal responsibility, and patients are expected to cooperate with MCH's procedures for obtaining financial assistance and to contribute to the cost of their care based on their individual ability to contribute. In the course of its mission, MCH makes no differentiation based upon an individual's race, creed, color, sex, national origin, sexual orientation, handicap, age or ability to meet the costs of health care.

3. **Definitions.**

3.1. **"Charity Care"** is defined as financial assistance to Financially Qualified Patients whose Family Income does not exceed 350% of the Federal Poverty Level.

3.2. **"Discount Payment"** is defined as partial financial assistance to patients whose Family Income exceeds 350% of the Federal Poverty Level by providing a discounted payment rate to patients who make full payment in full within certain deadlines.

3.3. **"Emergency Physician"** is defined as a physician and surgeon licensed pursuant to Chapter 2 (commencing with Section 2000) of the California Business and Professions Code who is credentialed by MCH and contracted by the hospital to provide emergency medical services in MCH's emergency department, except that an "Emergency Physician" shall not include a physician specialist who is called into the emergency department of a hospital or who is on staff or has privileges at the hospital outside of the emergency department. Emergency Physicians who provide emergency medical services to patients at MCH are required by California law to provide discounts to Financially Qualified Patients.

3.4. "Essential Living Expenses" is defined as any of the following: rent or house payment and maintenance; food and household supplies; utilities and telephone charges; clothing; medical and dental payments; insurance expenses; school or child care expenses; child and/or spousal support expenses; transportation and auto expenses, including insurance, gas, and repairs; installment payments; laundry and cleaning expenses; and other extraordinary expenses.

3.5. "Federal Poverty Level" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (1) of Section 9902 of Title 42 of the United States Code.

3.6. "Financially Qualified Patient" is defined as a patient with (a) Family Income that does not exceed 350% of the Federal Poverty Level, and (b) either (i) High Medical Costs, or (ii) is a Self-Pay Patient.

3.7. "Gross Charges" are the total charges at the MCH's full-established rates for the provision of patient care services before deductions are applied. Gross Charges are never billed to patients who qualify for Charity Care or Discount Payment

3.8. "High Medical Costs" is defined as either (a) annual out-of-pocket medical costs incurred by the patient at MCH that exceed 10% of the patient's Family Income in the prior 12 months; or (b) annual out-of-pocket medical costs incurred by the patient that exceed 10% of the patient's Family Income in the prior 12 months, for which the patient can provide documentation confirming that the patient or the patient's family paid out-of-pocket medical costs that exceed 10% of the patient's Family Income in the prior 12 months.

3.9. "Family Income" is defined as the combined income of (a) for persons 18 years of age and older: their spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not; or (b) for persons under 18 years of age: their parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

3.10. "Maximum Base Charge" means the maximum amount MCH could charge a patient under the Medicare program.

3.11. "Reasonable Payment Plan" means monthly payments that do not exceed 10% of a the patient's Family Income, excluding deductions for Essential Living Expenses.

3.12. "Self-Pay Patient" means a patient who does not have third party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by MCH. Self-Pay Patients may include patients eligible for Charity Care or Discount Payment.

4. Procedure

4.1. Responsible Department MCH's Admitting Department (the "Department") shall administer this policy, including making eligibility determinations and conducting all patient interviews and follow-ups related to this policy. The Department's financial counselor ("Counselor") shall be responsible for conducting patient interviews and making initial eligibility determinations.

4.2. Inquiry Regarding Coverage. Upon admission, or, if possible, prior to admission, a Counselor shall interview each patient (or the patient's family if they are a minor or lack capacity to participate in the interview) to determine if the patient has insurance or other coverage for services provided by MCH. The Counselor must specifically determine whether the patient has or is eligible for:

4.2.1. Private health insurance, including insurance offered through the California Health Benefit Exchange;

4.2.2. Medicare; or

4.2.3. Medi-Cal, the Health Families Program, the California Children's Services program, or any other state-funded program designed to provide health coverage.

4.3. Charity Care Eligibility Determination. In order to qualify for Charity Care, each patient, and their family if applicable, must complete MCH's Confidential Financial Assistance Application. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need. This application provides for the collection of information about the patient's Family Income and whether the patient faces High Medical Costs. Based upon the completed Confidential Financial Assistance Application and supporting documentation, any patient that is determined to be a Financially Qualified Patient shall qualify for Charity Care. The following documentation should be provided with the completed Confidential Financial Assistance Application:

4.3.1. Federal and State Tax Returns;

4.3.2. Payroll stubs (30 days or older);

4.3.3. Bank Statements;

4.3.4. Personal Declarations;

4.3.5. Evidence of high medical costs, including hospital and physician bills; and

4.3.6. Other Necessary Forms and Documents.

4.4. **Payment Rates for Financially Qualified Patients.** A Financially Qualified Patient shall be charged for services provided by MCH as follo.ws:

4.4.1. **275% or less of the Federal Poverty Level –** Charity Care (No Patient Responsibility to Pay):

4.4.2. **276% to 350% of the Federal Poverty Level** -Maximum Base Charge.

4.4.3. **Over 350% of the Federal Poverty Level** -Full liability (May Apply for Discount Care).

4.5. **Eligibility Evaluation Process.** During the registration process, or in an emergency as soon as possible, an MCH representative will (i) interview each patient, or their family member(s) as applicable, to determine if they have or are eligible for government health care program coverage, and (ii) provide each patient with a Confidential Financial Assistance Application. The patient will be informed that in order to qualify for financial assistance, the Confidential Financial Assistance Application must be completed and returned with all necessary supporting documentation. All patient accounts will be considered ineligible for Charity Care until the Confidential Financial Assistance Application is received with the appropriate documentation. Upon receipt of the Confidential Financial Assistance Application MCH's business office will determine whether the patient is a Financially Qualified Patient eligible for Charity Care. Once a determination of qualification is made, a letter indicating the determination status will be sent to the patient or family representative indicating one of the following:

4.5.1. **Approval.** The letter will indicate that patient is a Financially Qualified Patient eligible for Charity Care, the level of Charity Care received, and any outstanding amount owed by the patient.

4.5.1.1. **Additional Approval.** Charity Care accounts $20,000 or greater require the Director's and CFO's review and approval. Charity Care accounts $40,000 or greater require the Director's, CFO's, and CEO's review and approval.

4.5.2. **Denial.** The letter will indicate the reasons why the patient was determined not to be a Financially Qualified Patient, provide information regarding MCH's dispute resolution process, and identify any outstanding amount owed by the patient.

4.53. Pending. The patient will be informed as to why MCH could not determine whether they are a Financially Qualifying Patient. All outstanding information will be identified and requested.

4.6. Dispute Resolution. In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration. The written appeal should contain a complete explanation of the patient's rationale for qualification and reconsideration. All additional relevant documentation to support the patient's claim should be attached to the written appeal. MCH's Director of Business Office (the "Director") will review all appeals. After completing a review of the patient's claim, including the patient's written appeal and attached documentation, the Director shall provide the patient with a written explanation of findings and MCH's final determination of the patient's qualification for Charity Care. In the event that the patient believes a dispute remains after consideration of the appeal by the Director, the patient may request in writing an additional review by MCH's Chief Financial Officer (the "CFO"). The CFO shall review the patient's written appeal and documentation, as well as the Director's findings and determination. The CFO shall make a final determination and provide a written explanation to the patient. All determinations by the CFO are final. There are no further appeals.

4.7. Payment Plans for Financially Qualified Patients. All Financially Qualified Patients with Family Income between 276% and 350% of the Federal Poverty Limit shall be eligible to pay their debt through a payment plan.

4.7.1. Negotiated Payment Plan. MCH and each Financially Qualified Patient with Family Income between 276% and 350% of the Federal Poverty Limit shall negotiate a payment plan in good faith based upon the patient's outstanding debt, Family Income, and Essential Living Expenses.

4.7.2. Reasonable Payment Plan. If MCH is unable to negotiate a payment plan with a Financially Qualified Patient with Family Income between 276% and 350% of the Federal Poverty Limit, the patient will be placed on a Reasonable Payment Plan.

4.8. Failure to Adhere to Payment Plan. Once a payment plan has been approved, any failure to pay all consecutive payments due will constitute a default. The patient, or their guarantor, is responsible for contacting MCH's Business Office if circumstances change and payment plan terms cannot be met. The patient or guarantor will have the option to bring the account current with a lump sum payment or to renegotiate the payment plan. If the patient fails to renegotiate the payment plan or make full payment within thirty (30) days, the payment plan will be deemed inoperative and will follow MCH'S collection policy.

4.9. Discount Policy. Mission Community Hospital (MCH) is committed to the community to provide high quality health care services with efficiency and commitment to the human dignity and wellness of the individual, regardless to the patient's ability to pay. Discounted Care is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with MCH's procedures for obtaining discounts and to pay the amount of any copayment required. The qualification for discounted care generally will be for payment in full in one lump sum within 30 days of services.

4.9.1. Eligibility. A patient is eligible for Discount Care if they are a Self-Pay Patients treated at MCH whose Family Income exceeds 351% of the Federal Poverty Level.

. **4.9.2. Discount.** If payment is received in full within thirty (30) days from the first statement being issued to the patient, MCH will provide the patient with a 40% discount. After the first 30 days, MCH will award the patient a 20% discount for full payment on the account. Any deviation from this policy has to have the CFO or CEO approval.

4.10. Non-Determination of Patient Coverage Status. If MCH is unable to determine the coverage status of a patient prior to discharge, MCH may bill such patient at its full rates. However, at the time MCH sends its bill to such patients, MCH must also provide (1) a statement explaining that the patient may be eligible for insurance offered through the California Health Benefit Exchange, Medicare, Medi-Cal, the Health Families Program, the California Children's Services program, or any other state-funded program designed to provide health coverage, and (2) an additional statement informing the patient that they may qualify for Charity Care or Discount Care, as well as a copy of MCH's Confidential Financial Assistance Application. If such patients complete and return the Confidential Financial Assistance Application with necessary documentation, MCH must determine whether such patient qualifies for Charity Care or Discount Care, as discussed above.

4.11. Emergency Physicians. Under California law all Emergency Physicians must provide similar charity care and/or discounts to Financially Qualified Patients. However, MCH will not and is unable to enforce this law on behalf of patients because MCH's charity care and/or discount care obligations are limited solely to MCH's charges, and not the charges of Emergency Physicians.

APPLICATION INSTRUCTIONS

1. Please complete ***all*** areas on the attached application form. If any area does not apply to you, write N/A in the space provided.

2. Attach an additional page if you need more space to answer any question.

3. You ***must*** provide proof of income documents when you submit this application. The following documents are accepted as proof of income:

    - IRS tax returns
    - Payroll Stubs
    - Declarations
    - Other forms used to substantiate the need for Discount Care consideration
    - Letters

4. Your application cannot be processed until *all required* information is provided. This information will be eligible for 6 months.

5. It is important that you complete and submit the Confidential Financial Assistance Application along with all required attachments with in fourteen {14) days.

6. You must sign and date the application. If the patient/guarantor and spouse provide information, both must sign the application.

7. If you have any questions, please call the business office at {818) 904-3660.

8. Send your complete application to:
   Mission Community Hospital
   Patient Financial Services Department
   14850 Roscoe Blvd.
   Panorama City, CA 91402

Charity Cover Sheet

Patient Name:_____

Account(s) Number: _____

Date of Service:_____

Spouse or Guarantor:_____

Total Income:_____

Federal Poverty Level %_____

Total Charges: _____

Insurance Payment and Adjustment: _____

Amount of Charity Adjustment: _____

Remaining Balance: _____

Prior Patient Payments:_____

Total Balance Due from Patient: _____

Approved_____
Denied _____

Reviewed by_____

Approved by_____
Business Office Director

Approved by_____
CFO

Mission Community Hospital
Compassionate Healthcare. Quality Healthcare.™
14850 Roscoe Blvd. Panorama City, CA 91402 (818)904-3660

Date:

Account Number

Date(s) of Service:

Patient Name:

Balance Due:

Dear _____,

Your Payment Assistance Application and the information provided have been carefully evaluated. Regretfully, we have determined that you are not eligible for payment assistance based on the Facility's Payment Assistance Policy and criteria.

Should you feel that this decision was made in error, and you have additional information that may assist us in reconsidering you request, or if you have any questions regarding your account, please contact the Business Office directly at (818) 904-3660.

The current balance on your account is $_____.

Sincerely,

Holly Reich
Mission Community Hospital
Business Office Director

Mission Community Hospital

Compassionate Healthcare. Quality Healthcare.™

14850 Roscoe Blvd. Panorama City, CA 91402 (818)904-3660

Date:

Account Number
Date(s) of Service:
Patient Name:
Balance Due:

Dear _____,

Upon careful review of your Payment Assistance Application, your application is missing information. At this time we are holding your application until this information is received.

Information we need to complete your application is:

D Application needs to be signed.

D Income verification is missing for two {2) pay cycles.

D Other

As soon as you forward to us the missing information we would be able to process your application. Until this information is received you are responsible for the balance being billed.

Important Note: This account for Mission Community Hospital facility charges only and does not reflect any physician charges. If you were in our Emergency Department and receiving a bill for the physician fee, please give them a call.

AB 1503 (Chapter 445 Statutes of 2010) and became effective on January 1,2011. AB 1503 amended the Hospital Fair Pricing Policies Law to require emergency room physicians who provide emergency medical services in a general acute care hospital to develop a charity care and discounted payment policies to limit expected payment from eligible patients that are Uninsured or have high medical costs.

If you have any questions regarding your account, please contact the Business Office directly at (818) 904- 3660.

Sincerely,

Mission Community Hospital
Business Office Director

Mission Community Hospital

Compassionate Healthcare. Quality Healthcare.™

14850 Roscoe Blvd. Panorama City, CA 91402 (818)904-3660

Date:

Account #

Date ofSrvc:

Patient Name:

Balance Due:

Dear_____;

Upon careful review of your Payment Assistance Application we have approved the request to provide payment assistance to cover facility charges. This application will be effective for 6 months, then after the 6 months a new application will need to be completed. Please note this decision in no way obligates Mission Community Hospital to provide payment assistance in the future.

The breakdown is as follows and will show the amount that you are responsible for:

Total Account Balance	$_____
Less Payment Assistance	$_____
Amount Owed by Patient/Guarantor	$_____

Important Note: This account for Mission Community Hospital facility charges only and does not reflect any physician charges. If you were in our Emergency Department and receiving a bill for the physician fee, please give them a call.

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If you have any questions regarding your account, please contact the Business Office directly at

(818) 904-3660.

Sincerely,

Holly Reich
Mission Community Hospital
Business Office Director

2016 Federal Poverty Level Chart*

The Department of Health & Human Services (HHS) issues poverty guidelines that are often referred to as the "federal poverty level" (FPL). Federally-facilitated Marketplaces will use the 2016 guidelines when making calculations for the insurance affordability programs starting November 1, 2015.

Household Size	100%	138%	150%	200%	250%	300%	400%
1	$11,770	$16,242	$17,655	$23,540	$29,425	$35,310	$47,080
2	$15,930	$21,983	$23,895	$31,860	$39,825	$47,790	$63,720
3	$20,090	$27,724	$30,135	$40,180	$50,225	$60,270	$80,360
4	$24,250	$33,465	$36,375	$48,500	$60,625	$72,750	$97,000
5	$28,410	$39,205	$42,615	$56,820	$71,025	$85,230	$113,640
6	$32,570	$44,946	$48,855	$65,140	$81,425	$97,710	$130,280
7	$36,730	$50,687	$55,095	$73,460	$91,825	$110,190	$146,920
8	$40,890	$56,428	$61,335	$81,780	$102,225	$122,670	$163,360

*Chart is for 48 contiguous states and the District of Columbia; for Hawaii and Alaska please visit the website of the HHS Assistant Secretary for Planning and Evaluation (ASPE): http://aspe.hhs.gov/poverty/14poverty.cfm.

**Dollar amounts are calculated based on 100% column; rounding rules may vary across federal, state, and local programs.

Every year, the perimeters of the Federal Poverty Level (FPL) increase based on the cost of living. Families need to understand where they fall on the FPL so they know whether they are eligible for Medicaid in their state or whether they are eligible for a federal subsidy because they earn between 100 and 400 percent of the FPL, or whether they are eligible for a tax credit because they purchased a Silver plan and earn less than 250 percent of the FPL.

To qualify for Cost-Sharing, one must be enrolled in a Silver level plan through a Marketplace

Cost-sharing reductions are not available for coverage purchased outside of the Marketplace.

Individuals and families with household incomes generally up to 250% of the FPL may be eligible to receive cost-sharing reductions. Household income is determined by calculating a consumer's modified adjusted gross income (MAGI). Members of federally recognized tribes may qualify for additional cost-sharing benefits.

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PATIENT & FAMILY FINANCIAL STATEMENT
OF ASSETS, INCOME & EXPENSES

PATIENT, NAME _____ **ACCT #** _____ **DOS**_____

RESPONSIBLE PARTY			
NAME	MARITAL STATUS	SOCIAL SECURITY NUMBER - -	
STREET ADDRESS CITY, STATE ZIP	LENGTH AT THIS ADDRESS	HOME PHONE ( ) -	
EMPLOYER NAME STREET ADDRESS CITY, STATE ZIP	IF UNEMPLOYED, HOW LONG	BUSINESS PHONE ( ) -	
OCCUPATION / TITLE	MONTHLY EARNINGS – GROSS $	MONTHLY EARNINGS – NET $	CURRENT EMPLOYMENT LENGTH YR / MO

RESPONSIBILE PARTY - SPOUSE			
NAME		SOCIAL SECURITY NUMBER - -	
EMPLOYER NAME STREET ADDRESS CITY, STATE ZIP	IF UNEMPLOYED, HOW LONG	BUSINESS PHONE ( ) -	
OCCUPATION / TITLE	MONTHLY EARNINGS – GROSS $	MONTHLY EARNINGS – NET $	CURRENT EMPLOYMENT LENGTH YR / MO

RESPONSIBLE PARTY - DEPENDENTS		
DEPENDENT NAME [YEAR OF BIRTH] # 1 # 2 # 3 # 4	TOTAL NUMBER OF DEPENDENTS IN HOUSEHOLD	DO ANY OTHER PERSONS CONTRIBUTE TO MONTHLY INCOME? YES NO IF YES, AMOUNT $

ASSETS & INCOME PER MONTH		
INTEREST / DIVIDENDS $	WORKER'S COMPENSATION $	OTHER INCOME $
FOOD STAMPS / PUBLIC ASSISTANCE $	CHILD SUPPORT / ALIMONY $	IRA BALANCE $
SOCIAL SECURITY $	RENTAL INCOME $	CHECKING ACCOUNT BALANCE $
UNEMPLOYMENT COMPENSATION $	GRANTS $	SAVINGS ACCOUNT BALANCE $

EXPENSES PER MONTH		
RENT $	AUTO # 1 PAYMENT $ AUTO # 1 BALANCE $	CHILD SUPPORT $
MORTGAGE PAYMENT $ MORTGAGE BALANCE $	AUTO # 2 PAYMENT $ AUTO # 2 BALANCE $	VISA PAYMENT $ VISA BALANCE $
FOOD $	AUTO EXPENSES $	MASTERCARD PAYMENT $ MASTERCARD BALANCE $
UTILITIES $	AUTO INSURANCE $	DISCOVER PAYMENT $ DISCOVER BALANCE $
PHONE $	HEALTH INSURANCE $	OTHER CREDIT CARD PMT $ OTHER CREDIT CARD BAL $
WATER / SEWER $	LIFE INSURANCE $	INSTALLMENT LOAN PMT $ INSTALLMENT LOAN BAL $
CABLE $	MEDICAL/DENTAL PMT $ MEDICAL/DENTAL BAL $	MISCELLANEOUS EXPENSE $
TRASH $	PHYSICIAN PAYMENT $ PHYSICIAN BALANCE $	MISCELLANEOUS EXPENSE $

OFFICE USE ONLY

TOTAL INCOME GROSS $
TOTAL INCOME NET $
TOTAL EXPENSES $
NET INCOME (LOSS) $

TO MY KNOWLEDGE THE INFORMATION PROVIDED ABOVE IS TRUE. I AUTHORIZE A CREDIT BUREAU REPORT TO BE SECURED BY THE HOSPITAL OR ITS AGENT TO VERIFY MY FINANCIAL STANDING.

_____ _____
PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE

Please attach to this application your Proof of Income documentation for each income earner for the most current 3 month period. This may include paycheck stubs, employer income verification, W2, tax returns, Social Security letters and letters from family members certifying support amount provided.

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DECLARACIÓN FINANCIERA DEL PACIENTE Y FAMILIA -- PATRIMONIO, INGRESOS Y GASTOS

NOMBRE DEL PACIENTE _____ **CUENTA #** _____ **DOS** _____

PARTE RESPONSABLE

NOMBRE	ESTADO CIVIL	NÚMERO DE SEGURO SOCIAL	
DOMICILIO, CIUDAD, ESTADO, CÓDIGO POSTAL	AÑOS VIVIDOS EN ESTE LUGAR	TELÉFONO PARTICULAR ( ) -	
NOMBRE DE LA PERSONA O COMPAÑÍA QUE LO EMPLEA DOMICILIO CIUDAD,ESTADO, CÓDIGO POSTALP	SI HA ESTADO DESEMPLEADO, ¿POR CUANTO TIEMPO?	TELÉFONO EN EL EMPLEO ( ) -	
Ocupación/Título	GANANCIAS MENSUALES EN BRUTO $	GANANCIAS MENSUALES NETAS $	EMPLEO ACTUAL TIEMPO AÑO/MES

PARTE RESPONSIBLE/ ESPOSO O ESPOSA

NOMBRE		NÚMERO DE SEGURO SOCIAL - -	
NOMBRE DE LA PERSONA O COMPAÑÍA QUE LO/ LA EMPLEA DOMICILIO CIUDAD, ESTADO, CÓDIGO POSTAL	SI HA ESTADO DESEMPLEADO(A), ¿POR CUANTO TIEMPO?	TELÉFONO EN EL EMPLEO ( ) -	
OCUPACIÓN / TÍTULO	GANANCIAS MENSUALES – EN BRUTO $	GANANCIAS MENSUALES – NETAS $	EMPLEO ACTUAL TIEMPO AÑO / MES

PARTE RESPONSIBLE - DEPENDIENTES

NOMBRE DEL DEPENDIENTE [AÑO EN EL QUE NACIÓ] # 1 # 2 # 3 # 4	¿NÚMERO TOTAL DE DEPENDIENTES EN EL HOGAR?	OTROS EN EL HOGAR QUE CONTRIBUYAN ECONOMICAMENTE ¿INGRESOS? SI NO SI LA RESPUESTA ES SI, EL MONTO $

PATRIMONIO E INGRESOS MENSUALES

INTERESES / DIVIDENDOS $	COMPENSACIÓN AL TRABAJADOR $	OTROS INGRESOS $
BONOS ALIMENTICIOS (FOOD STAMPS) / ASISTENCIA PÚBLICA $	APOYO ECONÓMICO AL INFANTE O INFANTES / PENSIÓN EMANADA DE DIVORCIO $	SALDO DE CUENTA INDIVIDUAL DE JUBILACIÓN (IRA BALANCE) $
SEGURO SOCIAL $	INGRESOS POR RENTA(S) $	ESTADO DE SU CUENTA BANCARIA CORRIENTE $
COMPENSACIÓN POR DESEMPLEO $	BENEFICIOS (GRANTS) $	ESTADO DE SU CUENTA DE AHORROS $

GASTOS MENSUALES

RENTA $	AUTO # 1 PAGO $ AUTO # 1 SALDO $	AYUDA FINANCIERA -- HIJO O HIJOS $
PAGOS HIPOTECARIOS $ SALDO HIPOTECARIO $	AUTO # 2 PAGO MENSUAL $ AUTO # 2 SALDO $	PAGO DE TARJETA VISA $ SALDO DE TARJETA VISA $
ALIMENTOS $	GASTOS RELACIONADOS CON EL AUTO $	PAGO DE TARJETA MASTERCARD $ SALDO DE TARJETA MASTERCARD $
SERVICIOS PÚBLICOS (GAS, AGUA, ELECTRICIDAD, ETC.) $	SEGURO DE AUTO $	PAGO DE TARJETA DISCOVER $ SALDO DE TARJETA DISCOVER $
TELÉFONO $	SEGURO DE SALUD $	PAGO DE OTRA TARJETA DE CRÉDITO $ SALDO DE OTRA TARJETA DE CRÉDITO $
AGUA / ALCANTARILLADO $	SEGURO DE VIDA $	PAGO -- PRÉSTAMO A PLAZOS $ SALDO DEL PRÉSTAMO $
CABLE $	PAGOS --MEDICINA/DENTISTA $ SALDO DEL MONTO TOTAL $	GASTOS DIVERSOS $
SERVICIO DE BASURA $	PAGOS AL DOCTOR $ SALDO $	GASTOS DIVERSOS $

OFFICE USE ONLY TOTAL DE INGRESOS EN BRUTO $ TOTAL DE INGRESOS NETOS $ TOTAL DE GASTOS $ INGRESOS NETOS $	DE ACUERDO A MIS CONOCIMIENTOS, LA INFORMACIÓN PROPORCIONADA AQUÍ ARRIBA ES FIDEDIGNA. AUTORIZÓ UN REPORTE SOBRE MI SOLVENCIA ECONÓMICA DE UNA AGENCIA DE CRÉDITO PARA EL HOSPITAL O SU REPRESENTATE. _____ FIRMA DEL PACIENTE O PARTE RESPONSIBLE FECHA

Favor de incluir evidencia de las ganancias por cada ingreso actual de cada miembro de la familia de los últimos 3 (tres) meses. Esto incluye copia, talones de cheques, confirmación de sueldo del empleador, W2, impuestos de ingresos, cartas del Seguro Social, cartas del seguro por incapacidad, y cartas de miembros de la familia documentando el apoyo económico que proveen.