ALAMEDA HOSPITAL

Application for Community Care Program

Alameda Hospital encourages you to apply for the Alameda Hospital sponsored, Community Care Program. The Community Care Program is for individuals and families that meet the programs qualifications for low income and / or need help paying for your hospital bill for inpatient or outpatient care. If you qualify, the Community Care Program may offer reduced-price care and or a monthly payment program according to your income and ability to pay. If you have questions or need help completing this application, please call (510) 814-4645.

Patients are hereby notified that a physician employed or contracted to provide services in the emergency department of Alameda Hospital is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the current federal poverty level.

To apply for the Community Care Program, please complete the application on the following pages and return it along with all necessary supporting documentation to:

Alameda Hospital - Community Care Program Application
2070 Clinton Avenue
Alameda, CA 94501

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

If you have no income, or proof of income, please provide a letter explaining how you support yourself/family.

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

Alameda Hospital
Community Care Program Application

Please Print

Personal Information

Patient's Name: _____SS#: _____Date Birth: _____

If patient is a minor or a dependent, print name, date of birth and relationship of parent or other responsible party.

Name: _____Date of Birth: _____

SS#: _____Relationship: _____

Mailing Address: _____

Telephone Number: Home ( ) _____Cell No: ( ) _____Work ( ) _____

Name of employer: _____Telephone: _____

List all individuals residing in the household that you support: _____

Name _____ Age_____ Relationship_____

Name _____ Age_____ Relationship_____

Name _____ Age_____ Relationship _____

If additional space is needed please use back of page.

Health Insurance

Medical Insurance? Yes _____ No_____ If "yes,"

Print name of insurance company: _____ID Number: _____

Other Coverage? Yes ____ No ____ if yes, please identify other coverage: _____

Is the medical treatment because of a car accident or other third party injury? Yes ____No_____

Is the medical treatment because of an on-the-job injury or accident? Yes _____ No _____

If yes, Name the employer and place of where the injury took place: _____

_____

_____

Income: Applications without supporting documentation will be denied.
Be sure to **include** with your application documents that support the income amounts you list below.
For example:

- Pay stubs from all employment for the last two (2) months
- Last year's income tax return (including schedule C if self employed)
- Letters approving or denying unemployment compensation
- Written statements from employers or welfare agents.
- Students receiving financial aid, copy of award letter
- Copy of last two (2) months of Bank Statements.

	Person 1	**Person 2**	**Person 3**
Monthly Wages/Salary (before tax)	_____	_____	_____
Unemployment	_____	_____	_____
Social Security Pension	_____	_____	_____
SSI	_____	_____	_____
Food Stamps	_____	_____	_____
Alimony /Child Support	_____	_____	_____
Other (stocks, bonds, IRA's, etc.)	_____	_____	_____

Does your household have a checking account? Y N If yes name of bank: _____
Does your household have a savings account? Y N If yes name of bank: _____
Balance in checking: _____Balance in savings: _____□□□□__

Have you recently suffered severe financial hardship or personal loss (for example, other medical expenses, loss of job or wages, loss of home, auto, or other property)?

Yes ____ No _____ if yes, please explain: _____

_____

_____

Do the documents that you are including with this application show your current financial situation correctly? Yes _____ No ____ if no, why not?

_____

_____

If you are asking for Community Care for services already provided by Alameda Hospital, please list dates of services and what services you received:

Patient name	Account Number	Date of Service	Balance
1.			
2.			
3.			

Other Information you would like to give us: _____

_____

I understand that the information I am giving will be verified by Alameda Hospital and or may be reviewed by state and/or federal enforcement agencies and others as required. I certify that the above information is true and accurate to the best of my knowledge.

Applicant's Signature _____Date _____

Mail this application with all supporting documentation to:

Alameda Hospital - Community Care Program Application
2070 Clinton Avenue
Alameda, CA 94501

This section is not mailed to the patient

ALAMEDA HOSPITAL BUSINESS OFFICE USE ONLY

ELIGIBILITY DETERMINATION WORKSHEET

Patient Account Number _____

Date Application Received: _____Income Verified? Yes ____ No ____

The patient's gross family income is at or below 100% of the current federal poverty level: Y__N__

The patient's gross family income is at or below 350% of the current federal poverty level: Y__N__

Decision: [ ] A-100% Community Care Discount. **[ ] B-** Patient is to pay Medicare allowable amount.

Medicare Discount Calculations:

1-Alameda Hospital Charges: $_____

2- Medicare Allowable (Attach details) $_____

OTHER CALCULATIONS:

Beginning balance of patient's account $_____

Less medical coverage/amount payable by third party sources $_____

Less Community Care Discount $_____

Patient responsibility **$**_____

Expected payment in full: $_____

(patient may make monthly payments for up to 12 months if requested by the patient.)

The applicant's request for Community care has been denied for the following reason(s):

[ ] The application is incomplete. [ ] Not enough supporting documentation was received

[ ] Income cannot be verified. [ ] Over the income and property level.

Other: _____

_____

Prepared by: _____ Date: _____

Reviewed by: _____ Date: _____

Approved by: _____Date:_____