METHODIST HOSPITAL

The Next Generation of Care

Financial Assistance Program

If you need help paying for your medical services you may be eligible for Methodist Hospital's Financial Assistance Program. Please use this brochure to help determine if you qualify, as well as to apply for financial assistance. The Financial Assistance Program is a discretionary program offered by Methodist Hospital to all patients for services that are medically necessary. You must apply within six months of when you received the services you are applying for.

Applying for the Financial Assistance Program

You must meet the following criteria to be eligible for the Financial Assistance Program:

Types of Care: You must be receiving medically necessary services.

Other Payer Sources: We recommend that you apply for any private or public sector sources of medical financial assistance for which you're eligible, such as Medi-Cal or Healthy Families. You may be required to submit documentation of your application (or of the approval or denial of your application) to those sources. For services received which are the result of an accident you must show proof that there was no settlement before financial assistance can be considered.

Income: Your household income must be at or below 350 percent of the Federal Poverty Guidelines (FPG).

If your family size is:	Your annual income at 250% of FPG is equal to:	Your annual income at 300% of FPG is equal to:	Your annual income at 350% of FPG is equal to:
1	$29,425	$35,310	$41,195
2	$39,825	$47,790	$55,755
3	$50,225	$60,270	$70,315
4	$60,625	$72,750	$84,875

Special Circumstances: If you have unusually high medical costs or you've experienced a catastrophic event, you may be eligible for the Financial Assistance Program under special circumstances, regardless of whether you meet the household income requirements described above. To qualify, you'll need to provide income documentation and copies of your out-of-pocket medical expenses for the past 12 months indicating that these expenses equal 10 percent or more of your annual gross income.

Please note: Not all medical expenses qualify for financial assistance. Exclusions include, but are not limited to, expenses for premiums and dues, optical and hearing aids, medical supplies, health education classes, transportation, over-the-counter drugs and lifestyle medications (fertility, cosmetic, etc.).

Documentation required:

- A financial hardship letter, explaining your current financial situation.
- A copy of your most recent federal tax return with electronic submission verification or your signature (include all pages and schedules); and
- A copy of a current pay stub with year-to-date (YTD) income included. If YTD income is not listed, then copies of two consecutive pay stubs; or
- Copies of other documents to verify income, such as letters from disability, social security, unemployment agencies, or proof of alimony/child support payments; or
- If you have no income, a letter of support that explains your means of living, and
- A copy of the most recent bank statement for all accounts; and
- Any other documentation that may be requested

Be sure to send only photocopies as originals will not be returned to you. You'll have an opportunity to appeal the decision if your application is denied. Corrected and/or additional documentation will be required to support your appeal request. Upon finalization of your application, notification of your determination will be mailed to the address on file.

Submit Your Application To:

Methodist Hospital of Southern California
Business Office - Financial Assistance Program
P.O. Box 60016
Arcadia, CA 91066-6016

Phone: (626) 574-3594
Fax: (626) 821-6917

Hours: Monday-Friday, 8:00 am – 5:00 pm

Help in Your Language

Interpreter lines are available during regular business hours to assist you with questions regarding the financial assistance program. In addition, you may be able to get materials written in your language. For more information, call our Customer Service Line at (626) 574-3594, weekdays from 8:00 am to 5:00 pm.

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Methodist Hospital reserves the right to amend or retrace awards

APPLICATION

Patient Name: _____ Acct.# _____

_____

Patient/Guarantor (Responsible Party Information):

Name: _____

Relationship to Patient: _____

Address: _____

City, State, ZIP: _____

Phone Number: _____ Date of Birth:_____

Social Security Number: _____ Mother's Maiden Name:_____

Patient's Birth City/State/Country_____

Marital Status: ☐ Married ☐ Divorced ☐ Widow(er) ☐ Single ☐ Domestic partner

Spouse/Domestic Partner Information:

Name:_____

Social Security Number: _____ Date of Birth: _____

Household size (including yourself, your spouse or domestic partner and all dependents): _____

List All Household Members you Financially Support:

Dependent's name: _____

Date of birth: _____ Relationship: _____

Dependent's name: _____

Date of birth: _____ Relationship: _____

Dependent's name: _____

Date of birth: _____ Relationship: _____

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Employment Status:

Patient currently employed? ☐ Yes ☐ No Employer:_____

Spouse/Domstic partner employed? ☐ Yes ☐ No Employer: _____

SECTION A: **CURRENT MONTHLY GROSS INCOME**(All income from household must be reported).

If household income is zero, please initial here _____ and give a brief explaination of your financial situation: _____

_____

Who is the primary wage earner? (check one)	☐ Patient	☐ Spouse/Other
Gross monthly salary/wages (before taxes)	$ _____	$ _____
Cash income (not including gifts)	$ _____	$ _____
Gross Social Security income	$ _____	$ _____
Other income: ☐ Unemployment benefits	$ _____	$ _____
☐ State disability income	$ _____	$ _____
☐ Alimony or child support	$ _____	$ _____
☐ Pension income	$ _____	$ _____
☐ Rental property income	$ _____	$ _____
☐ Other sources (describe)	$ _____	$ _____
_____	$ _____	$ _____
Total monthly income:	$ _____	$ _____

SECTION B: **ASSETS** (MARKET VALUE OF THINGS YOU OWN)

Checking Acct Bank _____Acct#_____	$ _____
Savings Acct: Bank _____ Acct#_____	$ _____
Other Acct(s): Bank_____ Acct#_____	$ _____
Home Value:	$_____
Other Real Estate Value (explain):_____	$_____
Business Owned: _____	$_____
Franchise: _____	$_____
Other Assets: _____	$_____
Total Assets:	**$**_____

SECTION C: **MEDICAL EXPENSES**

(If your household income exceeds 350 percent of the Federal Poverty Guidelines (FPG) or if you're applying for special circumstances, you must complete this section. Copies of receipts and/or itemized invoices are required.)

Out-of-pocket medical expenses due or paid in the last 12 months:

☐ Hospital or office visits: $ _____
☐ Prescribed medications: $ _____
☐ Other expenses (please describe): $ _____

SECTION D: **MEDI-CAL SCREENING** (if you currently don't have Medi-Cal you must complete this section.)

If you've already applied for Medi-Cal and have a recent approval, denial, or pending letter, please submit it with your completed Financial Assistance application.

If you answer YES to any of the questions below, contact your local County Social Security Office.

- Are you younger than 21 or older than 65? ……☐ Yes ☐ No
- Are you currently enrolled in Supplemental Security Income (SSI)/State Supplemental Payment (SSP) or Security Disability Insurance?.....☐ Yes ☐ No
- Are you enrolled in CalWorks (AFDC), Entrant or Refugee Cash Assistance (ECA/RCA), Foster Care or Adoption Assistance Programs, or In-home Support Services (IHSS)? ……☐ Yes ☐ No
- Are you legally blind? ……☐ Yes ☐ No
- Are you permanently disabled? ……☐ Yes ☐ No
- Are you pregnant or have you been pregnant in the last three months..…… ☐ Yes ☐ No
- Have you been diagnosed with breast, cervical or prostate cancer?……☐ Yes ☐ No
- Are you being transferred to a skilled nursing facility or intermediate home care?...☐ Yes ☐ No
- Do you have children younger than 21 (including unborn or adopted children) in the home? ……☐ Yes ☐ No
    - If YES: Is one of the child's parents absent or deceased? ……☐ Yes ☐ No
      Is one of the child's parents permanently disabled? ……☐ Yes ☐ No
      Is the primary wage earner unemployed or working less than 100 hours per month? ……☐ Yes ☐ No

SECTION E: **MISSING INCOME DOCUMENTATION**

If you don't have income documentation, your signed attestation in this application ***may*** satisfy the income verification requirement if you meet any of the following criteria:

☐ I don't receive a formal pay stub from my employer.
☐ I receive no income. (if you check this box, you must provide a written explanation of your financial situation).
☐ I wasn't required to file a recent Federal or State Tax Return for the most recent tax year.

SECTION F: **FINANCIAL AGREEMENT AND CREDIT REPORT AUTHORIZATION**

I hereby declare under penalty of perjury that (i) all information set forth above in this application is true and accurate in all respects, and that all attachments are accurate copies of the original documents, or (ii) I am unable to provide documents relating to proof of income or other evidence of my income. I authorize employees and agents of Methodist Hospital of Southern California (MHSC) to investigate and verify that the information I have provided to it, including employment and credit

history, for the purpose of determining my eligibility to participate in the Financial Assistance Program. I also acknowledge and agree that I am liable to MHSC for any and all amounts owing to MHSC for medical goods and services that are not covered by the Financial Assistance Program (the remaining amounts).

Signature of Applicant/Guardian _____ Date _____

Signature of Spouse of Applicant/Guardian _____ Date _____