

Title: Patient Financial Assistance/Charity Care – Appendix C	Page 1 of 8
Policy #: MA1023 - Appendix C	
Type: Finance (1000)	
Standard: N/A	

APPENDIX C

FAP Application with Instruction Including the Medi-Cal Screening

The following are the Financial Assistance Program Application. This application, policy and other related information are also available translated into the following written languages:

Mandarin (Standard Chinese), Spanish and Cantonese (Standard Chinese).

The following pages are the Methodist Hospital of Southern Financial Assistance Program Application complete with the related instructions and includes the Medi-Cal Screening document.



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).



2018 Poverty Guidelines For The 48 Contiguous States And The District Of Columbia					
Persons in family / household	Poverty Base Line at 100%	Household Charity Level			
		200% and Below	201% to 250%	251% - 300%	301% - 350%
% WriteOff	➔	100%	75%	50%	25%
Income Levels for ALL income sources to the Household					
1	12,140	24,280	30,350	36,420	42,490
2	16,460	32,920	41,150	49,380	57,610
3	20,780	41,560	51,950	62,340	72,730
4	25,100	50,200	62,750	75,300	87,850
5	29,420	58,840	73,550	88,260	102,970
6	33,740	67,480	84,350	101,220	118,090
7	38,060	76,120	95,150	114,180	133,210
8	42,380	84,760	105,950	127,140	148,330
9	46,700	93,400	116,750	140,100	163,450
10	51,020	102,040	127,550	153,060	178,570
10+ for Each Person	4,320	8,640	10,800	12,960	15,120

Source: Federal Register /Vol. 83, No. 12 /Thursday, January 18, 2018 page: 2643

* For families/households with more than 10 persons add \$4,320 for each additional person.

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
300 West Huntington Drive
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 are able to get materials written in the languages outlined above (on page one of this appendix). 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/Domestic 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 explanation 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: <input type="checkbox"/> Unemployment benefits	\$ _____	\$ _____
<input type="checkbox"/> State disability income	\$ _____	\$ _____
<input type="checkbox"/> Alimony or child support	\$ _____	\$ _____
<input type="checkbox"/> Pension income	\$ _____	\$ _____
<input type="checkbox"/> Rental property income	\$ _____	\$ _____
<input type="checkbox"/> 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:

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- 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
 - o 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

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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 _____