Oak Valley Hospital District

Financial Assistance Application Instructions

If you need help paying your medical bill, you may be eligible for financial assistance from Oak Valley Hospital District. Any individual whose family income is at or below 400% of the Federal Poverty Level and is either uninsured or has high medical costs, may be eligible for the hospital's charity (free) care or discounted care. To determine eligibility for financial assistance, please follow the instructions below in completing the Financial Assistance Application, including submission of supporting documentation, as applicable.

You may be eligible for government programs such as Medi-Cal and other government-funded healthcare assistance programs. Additionally, you are welcome to obtain applications for coverage offered through the California Health Benefit Exchange: www.coveredca.com or through the Stanislaus County Community Service Agency at (877)652-0734 or http://www.csa-stanislaus.com.

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

2. **Discounted Care:** For purposes of determining eligibility for discounted care, we request that you submit documentation of income limited to (i) paystubs within six months before or after the patient is first billed or (ii) income tax returns from the year the patient was first billed or 12 months prior to when the patient was first billed. Patients that only apply for discounted care may receive less financial assistance than what may be available to them under the charity care program. If you only wish to apply for discounted care, please complete page two and three and sign and date page six of the application.

3. **Charity (Free) Care**: For purposes of determining eligibility for charity care, we may request that you submit documentation on all monetary assets (except statements on retirement or deferred compensation plans). Additionally, we may require waivers or releases from the patient or the patient's family, authorizing the hospital to obtain account information from financial or commercial institutions, or other entities that hold or maintain the monetary assets, to their value. Please complete the entire application and write N/A for any sections that are not applicable.

4. **Submission**: If you have questions, please call your account representative at 209-848-5366. Mail or deliver your completed application in person to: Oak Valley Hospital District Attn: Patient Financial Services Department – Financial Assistance 350 South Oak Ave. Oakdale, CA 95361.

PATIENT FINANCIAL ASSISTANCE APPLICATION
For Discounted Care, please fill out pages 2 - 3 and sign and date page 5.
For Charity Care, please fill out the entire application (pages 2 - 5).

ACCOUNT/MEDICAL RECORD#: _____

RESPONSIBLE PARTY NAME:	LAST	FIRST	M.I
PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY:			SOCIAL SECURITY #:
ADDRESS:			PHONE:
CITY, STATE & ZIP:			WORK/CELL PHONE:
EMPLOYER:	CONTACT PERSON/PHONE #		OCCUPATION:
SPOUSE INFORMATION			
NAME: LAST	FIRST	M.I	SOCIAL SECURITY #:
ADDRESS:			PHONE:
CITY, STATE & ZIP:			WORK/CELL PHONE:
EMPLOYER:	CONTACT PERSON/PHONE #:		OCCUPATION:

LIST ALL DEPENDENTS		
NAME	RELATIONSHIP	AGE

MONTHLY INCOME		
	PATIENT/ RESPONSIBLE PARTY	SPOUSE
GROSS WAGES (before deductions)		
OTHER INCOME:		
INTEREST & DIVIDENDS		
REAL ESTATE RENTAL/LEASE		
SOCIAL SECURITY		
UNEMPLOYMENT/ DISABILITY		
ALIMONY/CHILD SUPPORT		

For Discounted Care only, you may skip to page 5 to sign and date.

For Charity Care, please fill out the remainder of the application and sign and date on page 5.

MONTHLY EXPENSES	
RENT/MORTGAGE	
ALIMONY/CHILD SUPPORT	
FOOD/SUPPLIES	
CHILDCARE/SCHOOL	
UTILITIES (Gas, electric, water, phone etc.)	
INSURANCE PREMIUMS (Medical, home, auto)	
AUTO PAYMENTS	
TRANSPORTATION EXPENSES (fuel, repair costs)	
CREDIT CARD/PERSONAL LOAN PAYMENTS	
CURRENT MEDICAL PAYMENTS	
OTHER (provide description)	
ASSETS	
CASH ON HAND	
CHECKING ACCOUNT*	
SAVINGS ACCOUNT*	
TRUST ACCOUNTS	
OTHER SOURCES (STOCKS, BONDS)	
*BANK BRANCH(S) & ACCOUNT NUMBERS	

By signing below, I/We declare that all information provided is true and correct to the best of my/our knowledge.

I/We authorize Oak Valley Hospital District to verify any information listed in this application.

Patient Signature_____

Date_____

Spouse Signature_____

Date_____

Parent/Guardian_____

Date_____