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. **Charity (Free) or Discounted Care:** For purposes of determining eligibility for charity care or 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.

3. **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

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		

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_____