Madera Community Hospital

MADERA COMMUNITY HOSPITAL

Hospital Financial Assistance Discount Program Instructions & Application

Please complete the attached application in ink as fully as possible and sign where indicated.

In order to qualify for the MCH Financial Assistance Discount Program, you need to claim that you do not have the ability to pay for the services you are about to receive or have received and will have to complete the attached application. You will be asked to apply for State & Federal Public Health Programs that you may qualify for. Please complete the application in its entirety and provide as much support documentation of your income as possible. The more detailed information you provide will help us make a quicker decision about your qualification for the program and could prevent a delay in your care. Information such as check stubs, tax returns or other documents will help us confirm your income level and determine your qualification in this program.

Individuals who have no insurance coverage and who do not have the ability to pay for health care services may qualify for this program. Also, individuals who have primary coverage but have a deductible/co-pay or a share of cost may also qualify if they do not have the ability to pay for their share of the hospital charges. Depending on your income level and the number of people in your family, you may qualify for a 40% to 100% discount off the charges accumulated on your account for services received from the hospital.

Upon successful completion of the application and meeting other requirements, the hospital will review the information submitted and approve or deny your application. If denied due to incomplete information, you will have the opportunity to submit additional information that may help the hospital approve your participation in the program. You will receive a determination letter from the hospital within 10 business days from the submission of the application.

Most potential Financial Assistance Program Applicants will have to complete a Medi-Cal application before applying for the Hospital Financial Assistance Program. If the Medi-Cal application is approved, Medi-Cal will become your primary payer. If the Medi-Cal application is denied due to non-qualification, you can proceed with the Hospital Financial Assistance Discount Program Application. Individuals who refuse to go through the Medi-Cal application process will not be able to participate in this Program.

Approved Financial Assistance Applications are good for 3 months. After this time, the original approved application information will need to be updated for a determination of continuing in the program. The Hospital's Credit and Collections Department will contact patients about their continuation in the program. A patient who has unpaid balances from the prior 90 day period will not be eligible for continuing in the program until the previous balances are paid in full.

For more information about the MCH Financial Assistance Discount Program, please contact the Credit Office at (559) 675-5514.

MADERA COMMUNITY HOSPITAL

Hospital Financial Assistance Discount Program Application

Date of Birth ____/____/________

Patient's Name ______________________________

Patient's Address ______________________________

____

Phone Number (   ) ______________ Alternate Number (   ) ______________

Family Members (List all Dependents Below):

Number of Members in Family ________
(Include Patient, Spouse and Dependents)

Spouse ______________________________

Children ______________________________

____

____

____

EMPLOYMENT AND OCCUPATION:

Employer Name ______________________________ Position ______________

Address ______________________________

____

Contact Person ______________________________ Contact Phone Number ______________

Spouse Employer ______________________________ Position ______________

Address ______________________________

____

Contact Person ______________________________ Contact Phone Number ______________

CURRENT MONTHLY INCOME (Attach copies of check stubs)		**Patient**	**Spouse**
Gross Monthly Income From Employment (before deductions)			
Add:	Income from Operating Business (if Self-Employed)		
Add:	Other Income:		
	Interest and Dividends		
	Rental Income		
	Social Security		
	Other - Specify: ______________________		
	Alimony or Support Payments Received		
Subtract:	Alimony and/or Support Payments Made		
Equals:	**Currently Monthly Income**	$	$
	Patient and Spouse Total Combined Monthly Income	$	

By signing this form, I agree to allow Madera Community Hospital to verify employment and income for the purpose of determining my eligibility for a discount through the Financial Assistance Program. I understand that I may be asked to provide documentation of proof of employment and income amounts disclosed on this application.

______________________________ ____/____/________

Signature of Patient or Guarantor **DATE**