

Pipeline Health - Eligibility for Patient Financial Discount (Charity) Application & Instructions

INSTRUCTIONS

I. All items/question on the application form must be completed for the application to be processed.

Community Hospital Of Huntington Park, 2623 E. Slauson Ave., Huntington Park, CA 90255, Attn: Admissions Dept.

II. Patient signature & date is required. If guarantor/spouse provide information as well, all must sign.

Coast Plaza Hospital, 13100 Studebaker Road, Norwalk, CA. 90650, Attn: Admissions Dept

III. The attached worksheet proof of all income and expenses and supporting documentation must be received within 150 days of the initial patient billing.

East Los Angeles Doctor's Hospital, 4060 E. Whittier Blvd, Los Angeles, CA 90023, Attn: Admissions Dept.

Central Business Office, 12940 Telegraph Road Santa Fe Springs, CA 90670

IV. This application requires patient financial data.

Memorial Hospital Of Gardena, 145 West Redondo Beach Blvd., Gardena, CA 90247, Attn: Admissions Dept.

V. The completed application & required documentation to be submitted to the applicable address as follows:

VI. **Was a federal income tax return (Form 1040) filed by patient for the most recent calendar year?**

Yes No

4. If no patient income, documentation provided detailing how patient supports self/ /family.

Yes No N/A

If Yes, a copy of the IRS return including all schedules must be submitted and is attached.

Yes No

VII. **Does the patient currently have health insurance?**

Yes No

If No, patient did not file a federal income tax return, the following items must be provided:

If yes, what insurance does the Patient have?

1. A statement explaining why patient did not file a federal tax return.

Yes No

If insured patient has High Medical Costs, the following is required:

2. Two (2) most recent pay stubs from patient & family members residing in same household.

Yes No

1. Proof of patient's annual out-of-pocket costs incurred at the hospital within the twelve (12) months immediately preceding discharge

Yes No

3. The last two (2) months' of any financial/ bank statements/accounts

Yes No N/A

2. Patient's out-of-pocket medical expenses paid by you or your family within the twelve (12) months immediately preceding discharge.

Yes No

VIII. Patient Information:

1. Patient Name: _____
2. Patient SSN (Acct. #): _____ - _____ - _____
3. Patient Date of Birth _____
4. Patient Home Phone # _____
5. Patient Work Phone # _____
6. Patient Address: _____
7. Treating Facility: _____
8. Date of Service: _____

domestic partner, and dependent children under 21 years of age, whether living at home or not. If the patient is under 18 years of age, list the patient's caretaker relatives, parent(s), and other children younger than 21 years of age.

X. Responsible Party/ Guarantor Information

1. Relationship to Patient: _____
2. Guarantor Name _____
3. Guarantor SSN: _____
4. Guarantor DOB: _____
5. Guarantor Phone: _____
6. Guarantor Home Address: _____

IX. Patient Family Household Information

1. Spouse Name _____
2. Spouse SSN: _____ - _____ - _____
3. Spouse Birth Date: _____
4. List same household family members below*:

7. Guarantor Employer Name & Address: (If self-employed, give name of business)

Name	Age	Relationship

8. Position: _____
9. Work Contact (Name): _____
10. Work Phone: _____

*If patient 18 years age or older, list patient's spouse,

XI. Homeless Affidavit

1. Patient is currently homeless:

Yes No

I, (Insert Signature) _____,
hereby certify that I am homeless, have no permanent
address, no job, savings or assets, and no income other
than potential donations from others.

7. If yes, please provide the party responsible for
covering the losses (e.g., insurance carrier, claim #,
contact phone number, etc.)

XII. Insurance (Third Party Payer) Information

1. Patient has applied for Medi-Cal or any other income-
based/means tested government-sponsored
coverage in the last 12 months?

Yes No

2. If yes, is patient's application still pending?

Yes No

3. If a decision reached, was patient awarded
assistance?

Yes No

4. If yes, what amount was awarded? _____

5. If a decision was reached and assistance not
awarded please explain why the patient was denied?

6. Is a third party responsible for the medical care you
will receive or have received (e.g. a work-related
injury or auto accident)?

Yes No

XIII. Financial Worksheets

A. Current Income

Type	Patient/ Guarantor	Spouse
1. Gross Wages & Salary/Year (before deductions)		
2. (Self-Employment) Income:		
3. Social Security/ Unemployment/ Disability/ Other Public Assistance		
4. Alimony/ Child Support		
5. Real Estate Rentals & Leases		
6. Interest & Dividends		
7. All Other Sources (attach list)		
8. Total Income (add all lines above)		

B. Monetary Assets

Type	Patient/ Guarantor	Spouse
1. Checking Accounts		
2. Savings Accounts		
3. Certificates of Deposit		
4. Stocks and Bonds		
5. Other Bank Accounts & Investment		
6. Other monetary assets (attach list)		
7. Total Amounts (add lines 1- 6 above)		

C. Monthly Expenses

Type of Expense	\$ Monthly Amount
Rent or House Payment and Maintenance	
Food/Household Supplies	
Utilities & Telephone	
Clothin	
Medical/Dental Payments	
Insurance	
School or Child Care	
Child/ Spousal Support	
Transportation & Auto)	
Insurance	
School or Child Care	
Child or Spousal Support	
Transportation and Automobile Expenses (Including Insurance, Fuel, and Repairs)	
Installment Payments	
Laundry and Cleaning Expenses	
Other Unusual or Extraordinary Expenses* <i>(*Detailed information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (list as needed).</i>	
Total Monthly Essential Living Expenses (add lines 1 – 12 above)	

application and could result in legal actions being taken against me/us.

- Patient authorizes Pipeline Health to verify any information listed in this application, including employment status and credit history, for the purpose of determining eligibility for patient discount.
- Patient fully understands that the Patient (Charity) Discount programs are a “Payor of Last Resort.”
- Patient therefore hereby assign to Pipeline Health all benefits due from any liability action, personal injury claims, settlements, and all insurance benefits which may become payable, for illness/ injury for which Pipeline Health or its subsidiaries provided care.

XIV. Required section VII financial worksheet fields for monetary assets, income, and expenses are all complete:

Yes No

Signature of Patient/Guarantor

XV. Guarantor Attestation

Patient declares under the penalty of perjury that all t information provided herein is true and correct to the best of his/her knowledge and further understands and agrees as follows:

- Providing false or misleading information, or the intentional omission of material information, will result in the denial of this

Date

Signature of Spouse

Date