Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at PeaceHealth.

PeaceHealth provides financial assistance in accordance with state and federal requirements to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. To view PeaceHealth's Financial Assistance Policy and additional information, please visit **peacehealth.org**.

What does financial assistance cover?
The hospital financial assistance covers appropriate hospital-based services provided by PeaceHealth depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: Please contact Customer Service at 877-202-3597. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- Provide us information about your family
  Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- Provide us information about your family's gross monthly income (income before taxes and deductions)
- Provide documentation for family income
- Attach additional information if needed
- Sign and date the form

Note: You do not have to provide a Social Security number to apply for financial assistance. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail, email or fax completed application with all documentation to: PeaceHealth Patient Financial Services, PO Box 748632, Los Angeles, CA 90074-8632. Email: financialassistance@peacehealth.org Fax: (360) 729-3047. Be sure to keep a copy for yourself.

To submit your completed application in person: Please contact Customer Service for the closest drop-off location at 877-202-3597.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly! You may receive bills until we receive your information.

PeaceHealth

22-ADMIN-373800

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Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

Please mail completed application to PeaceHealth, PO Box 748632 Los Angeles, CA 90074-8632

SCREENING INFORMATION

Do you need an interpreter? ❑ Yes ❑ No *If Yes, list preferred language:* _____

Does the patient receive state public services such as Medicaid, TANF, Basic Food, or WIC? ❑ Yes ❑ No

Is the patient currently homeless? ❑ Yes ❑ No

Is the patient's medical care need related to a car accident or work injury? ❑ Yes ❑ No

PLEASE NOTE

- *We cannot guarantee that you will qualify for financial assistance, even if you apply.*
- *Once you send in your application, we may check all the information and may ask for additional information or proof of income.*
- *Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.*

PATIENT AND APPLICANT INFORMATION

Patient First Name	Patient Middle Name		Patient Last Name
❑ Male ❑ Female ❑ Other *May Specify:* _____	Birth Date		Social Security Number (Optional)
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (Optional)
Mailing Address _____ _____ City State Zip			Main Contact Number(s) (_____) _____ (_____) _____ Email Address: _____

Employment status of person responsible for paying bill

❑ Employed *date of hire:* _____ ❑ Unemployed *how long unemployed:* _____

❑ Self-Employed ❑ Student ❑ Disabled ❑ Retired ❑ Other: _____

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE _____ *Use the Additional Family Information section on page 4 if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?

All adult family members' income must be disclosed. Sources of income include, for example:

Wages ■ Unemployment ■ Self-employment ■ Worker's compensation ■ Disability ■ SSI ■ Child/spousal support

Work study programs (students) ■ Pension ■ Retirement account distributions ■ Other *Please explain:* _____

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INCOME INFORMATION

REMEMBER: You must include proof of income with your application.

You must provide information on your family's income. Income verification is required to determine financial assistance.

All family members 18 years old or older must disclose their income. Please provide proof for every identified source of income. Acceptable documentation of income must include one of the following:

- A "W-2" withholding statement; or
- Pay stubs ; or
- An income tax return from the most recently filed calendar year ; or
- Form approving or denying eligibility (non-covered charges) for Medicaid and/or state-funded medical assistance, or, in the alternative, from any payer, such as charges for days beyond a length of stay limit, the patient's benefits have been exhausted, balance from restricted coverage, Medicaid-pending accounts, and payer denials; or
- Forms approving or denying unemployment compensation; or
- Written statements from employers or welfare agencies ; or
- In the absence of the above forms of income documentation, a written and signed statement from the Guarantor will be accepted as proof of income.

ADDITIONAL INFORMATION

Please use the additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that PeaceHealth may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date

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Please mail completed application to PeaceHealth, PO Box 748632 Los Angeles, CA 90074-8632.

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FAMILY INFORMATION CONTINUED (IF NEEDED)

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?

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Work study programs (students) ■ Pension ■ Retirement account distributions ■ Other *Please explain:* _____

ADDITIONAL INFORMATION (IF NEEDED)

Please use this section if you have other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.