**Dignity Health Medical Foundation**

## Financial Assistance Application Form Instructions

This is an application for financial assistance at a DHMF clinic.

**DHMF provides financial assistance** to people and families who meet certain income requirements. You may qualify for free care or discounted care based on your family size and income, even if you have health insurance. Assistance is provided for those patients whose family income is lower than 500% of the Federal Poverty Level Guidelines. Information on the Federal Poverty Level Guidelines can be found at **http:// aspe.hhs.gov/poverty-guidelines**.

**What does financial assistance cover?** The DHMF financial assistance covers appropriate clinic-based services provided by Dignity Health 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:** You may obtain help for any reason, including disability and language assistance at: 855-424-0997

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

- □ **Provide us information about your family**
- □ **Provide us information about your family's gross monthly income (income before taxes and deductions)**
- □ **Provide documentation for family income**
- □ **Provide documentation for family assets**
- □ **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 or fax completed application with all documentation to:** Dignity Health Medical Foundation, Attn: Financial Assistance 3400 Data Drive, Rancho Cordova, CA 95670. Be sure to keep a copy for yourself.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 30 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.**
**Dignity Health Medical Foundation**
**Financial Assistance Application Form – Confidential**

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

| |
|---|
| Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:* |
| Has the patient applied for Medicaid? □ **Yes** □ **No** *May be required to apply before being considered for financial assistance* |
| Does the patient receive state public services such as food stamps or WIC (Women, Infants, and Children)? □ **Yes** □ **No** |
| Is the patient currently homeless? □ **Yes** □ **No** |
| Is the patient's medical care related to a car accident or work injury? □ **Yes** □ **No** |
| List of DHMF clinics where you were treated: |
| |
| ● We cannot guarantee that you will qualify for financial assistance, even if you apply.<br>● Once you send in your application, we may check all the information and may ask for additional information or proof of income. |

| | | | |
|---|---|---|---|
| | | | |
| Patient first name | Patient middle name | | Patient last name |
| Date of Birth | Patient Account Numbers: | | Patient Social Security Number (optional*) |
| Person Responsible for Paying Bill | Relationship to Patient | Birth Date | Social Security Number (optional*) |
| _____<br>Mailing Address<br><br>_____<br>City State Zip Code | | | Main contact number(s)<br>( ) _____<br>( ) _____<br>Email Address:<br>_____ |

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Employment status of person responsible for paying bill

□ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed:_____) □ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

List family members in your household, including you. A patient's "Family" includes:

- For persons 18 years of age and older - a spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not.
- For persons under 18 years of age - a parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

**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? |
|---|---|---|---|---|---|
| | | | | | Yes / No |
| | | | | | Yes / No |
| | | | | | Yes / No |
| | | | | | Yes / No |
| | | | | | Yes / No |
| | | | | | Yes / No |

**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 identify:* _____*)*

***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.**

**<u>All family members 18 years old or older must disclose their income. Please provide proof for every identified source of income.</u>**

**<u>Examples of proof of income include:</u>**

- Last year's income tax return, including schedules if applicable; or
- A "W-2" withholding statement; or
- Current pay stubs (*3 months*); or
- Written, signed statements from employers or others; AND
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with a signed statement explaining how you support basic living expenses (such as housing, food, and utilities).

***REMEMBER**: You must include proof of assets with your application.*

**You must provide information on all assets owned by any family member. Asset verification is required to determine financial assistance.**

**<u>All family members 18 years old or older must disclose their available financial resources. Please provide proof for every identified asset source Examples of proof of income include:</u>**

- Current bank statements (showing most recent 3 months)
    - Checking Account(s)
    - Savings Account(s)
- Investments, including stocks and bonds
- Trust funds
- Money Market Account(s)
- Mutual funds
- Other investment funds that will not incur a penalty if funds are withdrawn.

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Please attach an 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.

I understand that Dignity Health Medical Foundation 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 certify that the information I have provided is true and accurate to the best of my knowledge.
- I will independently or with the assistance of DHMF personnel apply for ANY and ALL Assistance which may be available through federal, state, local government and private sources to help pay this healthcare bill.
- I understand that if I do not cooperate with Dignity Health Medical Foundation in providing requested information, my application may be denied.
- I understand that the information which I submit is subject to verification by Dignity Health Medical Health, including credit reporting agencies and subject to review by Federal and/or State agencies and others as required.
- I understand that additional information may be requested in order to qualify for assistance.

If you receive payment from an insurance company, workers compensation plan, or any other third party, you agree to inform DHMF of any such payment. DHMF retains its right to collect the original, full billed charges should a third party provide you with payment for the DHMF's services.

_____ _____

Signature of Person Applying Date