El Camino Health

Hospital Campuses

2500 Grant Road
Mountain View, CA 94040
650-940-7000

815 Pollard Road
Los Gatos, CA 94032
408-378-6131

elcaminohealth.org

Attached is an application to the El Camino Hospital Charity Care Program. Please complete, sign and return the application to our office along with the documentation listed below:

(1) Proof of income is a requirement for all applicants and cannot be waived.
If the patient is under 18 years of age or disabled, proof of income for both of the patient's parent(s) or guardian(s) would be required. If the patient is 18 years of age or older, their own POI would be required. If the patient is married or has a domestic/life partner, POI for that spouse/partner must also be received.

Documents that are considered to be acceptable proof of income are listed below. Applicants are required to choose one of the options below for submission with their application.

* A copy of 2 most recent Payroll/Unemployment/Pension/Disability paystubs for
* A full copy of the Federal Income Tax Return for the most recent tax year (A Joint return would be POI for both the applicant and spouse/partner)
* A copy of a W-2 or SSA1099 form for the most recent tax year

(2) ***Medi-Cal Notice of Action*** if the patient/applicant is uninsured. The Notice of Action confirms whether or not the patient/applicant is eligible for Medi-Cal benefits and is issued directly by Covered California/Medi-Cal.

(3) For insured patients please submit ***copies of paid medical out-of-pocket expenses*** for

the 12 months prior to the submission date of this application. Please keep in mind that your ***paid medical out-of-pocket expenses need to total up to 10% of your annual income to qualify*** for our Charity Care program.

Documents can be submitted to our office in any of the following ways:

Scan and email to:	charity_care@elcaminohealth.org
Fax to:	650-966-9334 Attention: Charity Care
Mail/Drop off to:	El Camino Health Attn: Charity Care/Patient Financial Services 2505 Hospital Drive Mountain View, CA 94040

For your convenience a complete copy of our Financial Assistance/Charity Care Policy can be found on the Financial Assistance page of our website, elcaminohealth.org.

If you have questions regarding the application process please contact one of our Customer Service Team at 650-940-7220 or 800-665-6540. Our Staff is available to assist you, Monday through Friday, 9 a.m. to 4 p.m.

Charity Care Application

Patient Information:

Account Number(s): _____

Name: _____ Date of Birth: _____

Applicant (Guarantor) Information: Relationship to patient: _____ Self _____ Parent/Guardian

Name: _____ SSN#:_____

Address: _____ City _____

State, Zip: _____ Telephone Number: _____

Marital Status :_____ Name of Spouse: _____

No. of Dependents: _____ Age(s) of dependent(s) :_____

Employers Name/Address/Telephone Number : _____

_____

Annual Family Income: $_____ (Income documentation is required.)

Are you eligible for coverage with a Commercial Health Insurance? □ Yes □ No
If yes, please provide the name of your carrier and your identification number: _____

Are you eligible for coverage with Medicare? □ Yes □ No
If yes, please provide the scope of your coverage (A, B or both) and your identification number: _____

Are you eligible for coverage with Medi-Cal or other state medical assistance program? If yes, please provide the County of coverage and your identification number: _____ □ Yes □ No

Are you eligible for coverage with a Travelers/Out-of-Country insurance? □ Yes □ No
If yes, please provide the name of your carrier and your identification number: _____

Is your treatment related to an injury covered by Workers Compensation? □ Yes □ No
If yes, please provide the name of the carrier and your claim number: _____

Is your treatment covered by Third Party Liability such as an Auto carrier? □ Yes □ No
If yes, please provide the name of the auto carrier or attorney and your case or claim number: _____

Is your treatment a result of you being a victim of a crime incident? □ Yes □ No
If yes, please provide the name of your Case Worker and your case number: _____

Patient's Name: _____ Date: _____

Charity Care is being requested for: (Please complete all that apply)

- Total charges on patient account(s) $_____
  (For uninsured patients only)
- Balance after insurance payment(s) $_____
  (Co-Insurance, Co-Payment, Deductible)

Note: Medi-Cal Share of Cost amounts are ineligible for the Charity Care Program.

Additional item for consideration:

If a patient/applicant, or their immediate family members*, incur medical expense out-of-pocket** with any medical provider other than our facility within the 12 month period before application date, the out-of-pocket amount can be considered in our review. The patient/applicant would be required to provide documentation (statements) from the medical providers to confirm the amount listed below.

- Total out-of-pocket expense $_____

*Using the Census Bureau definition a family is a group of two or more people who reside together and who are related by birth, marriage or adoption. For purposes of this policy independence is evidenced by living away from home and being married, in the military or meeting any of the other conditions for independence as defined in Free Application for Federal Student Aid (FAFSA) which is available at fafsa.ed.gov.
**Out-of-Pocket expenses are all patient medical bill balances, co-insurance, co-payment or deductible amounts.

Note: Medi-Cal Share of Cost amounts cannot be included as out of pocket expenses.

The Charity Care program for our facility does not apply to charges billed by any physician who may have participated in your care.

I attest that the financial information I have provided is complete and accurate and I agree that your facility may verify this information. I agree to notify your facility of any changes in my financial circumstances and to provide, upon request, insurance eligibility status.

I agree that your facility may disclose the information contained on this application to any third party who may help fulfill my request for charity care or financial need discounts.

Patient/Applicant's Signature_____ Date _____
(If the patient is under 18 years of age, the signature of a parent or guardian is required)

Patient Representative's Signature_____ Relationship _____
(If the patient is unable to sign because of illness or disability.)