ALAMEDA HEALTH SYSTEM

Hospital Financial Assistance and Charity Care

Dear Patient and Family:

Thank you for choosing Alameda Health System. We are committed to providing financial assistance to qualified low income patients and patients who have insurance that requires the patient to pay a significant portion of their care. Patients who meet certain income requirements may qualify for financial assistance or Charity Care. To view a complete copy of our Financial Assistance/Charity Care Policy please visit our Financial Assistance page on our website at www.alamedahealthsystem.org.

For your convenience attached is an application to the Alameda Health System Financial Assistance and 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 patient's parent(s) or guardian(s) would be required. If the patient is 18 years of age or older, their own proof of income would be required. If the patient is married or has a domestic/life partner, proof of income for that spouse/partner must also be received.

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

- A copy of 2 most recent Payroll/Unemployment/Pension/Disability paystubs
- A full copy of the Federal Income Tax Return for the most recent tax year
  (A Joint return would be proof of income for both the applicant and spouse/partner)

(2) 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:

Fax to: (510)437-6428
Mail to: Highland Hospital
Attn: Enrollment Services QIC # 22105
1411 East 31st Street
Oakland CA 94602
To submit in person: Take the application to your nearest Enrollment Services Department located at any of our Alameda Health System facilities.

ALAMEDA HEALTH SYSTEM

After submitting your application, the Enrollment Services Department will review the information and notify you in writing regarding your eligibility. We may contact you for additional information if necessary. If you have questions regarding the application process please contact one of our Financial Counselors at 510-437-4961 our staff is available to assist you, Monday through Friday, 8:30 a.m. to 5:00 p.m.

Please make sure to submit your application promptly.

ALAMEDA HEALTH SYSTEM

Hospital Financial Assistance and Charity Care Application

Please fill out all information completely. If it does not apply, write N/A.

I received services at:		
☐ Highland Hospital	☐ San Leandro Hospital	☐ Alameda Hospital
☐ Fairmont Hospital	☐ John George Psychiatric Hospital	
Patient Information		
Account Number(s):		
Name:	Telephone Number:	
Address:		☐ Homeless
City:	State:	Zip:
Applicant (Guarantor) Information		
Relationship to patient: ☐ Self	☐ Parent/Guardian	
Name:		Date of birth:
SSN:	Telephone Number:	
Address:		
City:	State:	Zip:
Employment Status:	Employer Name:	
Address:		
City:	State:	Zip:
Employer Telephone Number:		
Marital Status:		
Number of Dependents:	Age(s) of Dependents:	
Annual Family Income:	*(Income documentation is required)*	
Spouse Information		
Name:	Employer Name:	
Employer Address:		
City:	State:	Zip:
Employer Phone Number:		
Additional Information		
Are you eligible for coverage with a Commercial Health Insurance? If yes, please provide the name of your Health Insurance, Phone Number and Identification Number:	☐ Yes	☐ No
Are you eligible for coverage with Medicare? If yes, please provide the scope of your coverage (A, B or both) and your identification number:	☐ Yes	☐ No
Are you eligible for coverage with Medi-Cal or any other state medical assistance program? If yes, please provide the County of coverage and your identification number:	☐ Yes	☐ No

ALAMEDA HEALTH SYSTEM

Is your treatment related to an injury covered by Workers Compensation? If yes, please provide the name of the Workers Compensation Carrier and your claim number:	☐ Yes ☐ No
Is your treatment covered by Third Party Liability? (such as a car accident of slip and fall)? If yes, please provide the name of the auto carrier and your claim number:	☐ Yes ☐ No
Is your treatment a result of you being a victim of a crime incident? If yes, please provide the name of your Case Worker and your case number	☐ Yes ☐ No

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

Total charges on patient account(s) (for Uninsured Patients Only) $_____

Balance After Insurance Payments $ _____(Co-Insurance, Co-Payment, Deductible)

Note: Medi-Cal Share of Cost amounts are Not eligible for the Charity Care Program.

Additional item for consideration:

If a patient/applicant, has 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 $____

Out-of-Pocket expenses are all patient medical bill balances, co-insurance, co-payment or deductible amounts.

The Charity Care program for AHS does not apply to charges billed by any physician who are not billed by AHS.

Patient Attestation

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.

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)

ALAMEDA HEALTH SYSTEM

For Internal Use:			
IDENTIFICATION/ADDRESS VERIFICATION		INCOME VERIFICATION	
☐	Driver's License	☐	Paycheck stubs
☐	Voter's Registration Card with picture	☐	Award letter / checks - Pensions, Soc. Sec., VA
☐	Check Cashing card with photo	☐	Statement of other income: (contributions, refunds, child support, etc)
☐	Soc. Sec. Card or Soc. Sec. document	☐	State Unemployment / Disability award letter application
☐	Birth Certificate	☐	Student Loan letter / loan grant papers
☐	School ID Card	☐	Self-employment info: Last year's income tax documents, current ledgers / inventory including equipment / supplies
☐	US Citizenship / Alien Status documents (passport)	☐	Unemployment check stubs
☐	Marriage record	☐	Disability check stubs
☐	Divorce decree	☐	Worker's Comp check stubs
☐	Work / Building pass	☐	Retirement check stubs
☐	VISA	☐	Income Tax Documentation (Prior Yr.)
☐	Tribal Enrollment Card	☐	Other Income – Savings account: annuity statements, etc. (Do not include IRA's or deferred compensation retirement plans)
☐	Church membership / baptism /confirmation record	☐	Free Room and Board Statement
☐	Other Written Documentation (Specify)	☐	Sworn Statement

Application Reviewed by Eligibility Specialist:	Date
Approved By:	Date