El Camino Health®

Hospital Campuses

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

815 Pollard Road
Los Gatos, CA 95032
408-378-6131

elcaminohealth.org

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

***Proof of Income is a requirement for all applicants and cannot be waived.***

Proof of income from other household members will be required.

- If the patient is 18 years of age and older, proof of income would be required from the patient's spouse, domestic partner, and/or dependent children under 21 years of age, whether living at home or not.
- If, the patient is under 18 years of age, proof of income would be required from the patient's parent(s), caretaker relative(s) (including guardians), and/or other children under 21 years of age of the parent or caretaker relative.

Financial assistance/charity care is available based on family income below 400% of federal poverty level either currently or over the last 12 months.

Documents that are considered acceptable proof of income are listed below.

* A complete 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 two most recent Payroll/Unemployment/Pension/Disability paystubs
* A copy of a W-2 or SSA1099 form for the most recent tax year

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

**Scan and email:** charity_care@elcaminohealth.org

**Fax:** 650-966-9334 Attention: Charity Care

**Mail/Drop off:** Attn: Charity Care/Patient Financial Services
2505 Hospital Drive, 2nd floor
Mountain View, CA 94040

If you have questions regarding the application process, please contact our Customer Service Team from 9:00 a.m. to 4:00 p.m., Monday through Friday, at 650-940-7220 or 800-665-6540

# Charity Care Application

**Patient Information:**

Account Number(s): _____

Name: _____ Date of Birth: _____

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**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.)

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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.

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**Additional item for consideration:**

If a patient/applicant, or their immediate family members*, incur medical expense out-of-pocket** with any medicalprovider 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 $_____

* Your family means: (1) For Persons 18 years of age and older: Patient's spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not; or (2) For Persons under 18 years of age: Patient's parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.
**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.

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

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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 helpfulfill 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.)

02/22