JOHN MUIR HEALTH

5003 Commercial Circle
Concord, CA 94520

John Muir Health is pleased to offer a program for our patients who need assistance in paying their medical bills. The program is entirely self-funded by John Muir Health as part of our core commitment to the community we serve. Please be aware that acceptance into the John Muir Health Patient Financial Assistance Program will not cover services of providers who are not employed directly by the medical center or for services that are provided outside of one of our hospitals. The program only covers accounts for hospital services rendered for which an initial bill has been provided to you and does not automatically cover future services.

For your application to be considered, certain documents are required. Please provide the information as indicated below for yourself and any adults residing in your household who reports you on their Tax Returns or provides support to your living expenses, as the Financial Assistance Program is based on household income. If you are unable to provide the following information, **please provide a written explanation**.

Initial Qualifying Requirement:
☐ Your household income must be at or below 400% of the Federal Poverty (FPG) guidelines based on members of the household. Please reference table below for income thresholds.

Family Size	1	2	3	4	5	6	7	8	9
400% of FPG	62,600	$84,600	$106,600	$128,600	$150,600	$172,600	$194,600	$216,600	$222,100

Documentation Requirements:

☐ **Tax return** for the year in which the patient was first billed; or 12 months prior to when the patient was first billed OR **pay stubs** within a 6 month period before or after the patient is first billed by the hospital for each Family member. *[Family member defined as (1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not. (2) For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parents or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.]*

If you do not have insurance:

☐ Recommend patient to apply for medical coverage through Covered California (888) 975-1142, if over 18 years old, and provide a copy of the determination letter indicating whether applicant denied or is eligible for a program. Attach a copy of the insurance card if applicable.

☐ If the patient is a minor or is supporting minor children, patient is recommended to apply for Medi-Cal (800) 709-8348 and provide a copy of the determination letter indicating whether denied or eligible for a program.

In addition, if you have insurance:

☐ Proof that your medical expenses (includes all considered in your household) have exceeded the lesser of 10% of your household family income in the past 12 months of application or your current family income. List of medical bills paid or not.

NOTE: If your signed application and completed information is not received, John Muir Health is unable to consider your request for assistance and further collection activity will continue.

If you have any questions, please contact our Customer Service Department at: (925) 947-3336.

1. PATIENT INFORMATION		
Last Name	**First Name**	**DOB:**

2. APPLICANT INFORMATION	**Relationship to Patient** ☐Self ☐Spouse ☐Parent ☐Other		**Marital Status** ☐Married ☐Single	
Last Name	**First Name**		**Date of Birth**	**Social Security Number**
Street Address (No PO Boxes)	**City**	**State**	**County**	**Zip**
How long at this address?	**Are you currently employed?**			**How long?**
Home Phone	**Cell Phone**			**Other Contact**

3. GENERAL INFORMATION				
Does the patient have a Legal Conservator? ☐Yes ☐No (If yes, please provide the Conservator information below)				
Last Name	**First Name**	**Relationship to Patient** ☐Self ☐Spouse ☐Parent ☐Other _____		
Street Address	**Apt/Ste**	**City**	**State**	**Zip**

4. FAMILY AND LIVING ARRANGEMENT INFORMATION
(For the person financially responsible for the account, if different than the patient)

Including yourself, how many people live in your household? _____
How many household members contribute to your finance _____
How many household members live in your household under the age of 21 years, which you are financially responsible for?_____

Name	Age	Income	Relationship		

Do you own your home? ☐Yes ☐No
Are you living in the residence of your parent or another adult? ☐Yes ☐No
Do you pay rent? ☐Yes ☐No Amount of rent per month? _____

Do you currently receive financial assistance for attending school? ☐Yes ☐No
Total amount of financial support: $_____/semester or $_____/ year

Do you currently receive government support? Please check all that apply.
☐ Food Stamps ☐Housing Assistance ☐Payment of work injury
☐ Disability ☐Welfare/WIC
☐ Other (please specify): _____

Does your parent or guardian claim you as a dependent on their income tax? ☐Yes ☐No

Did you file taxes last year? ☐Yes ☐No
Was your adjusted gross income less than $ 14,600 ☐Yes ☐No

5. EMPLOYMENT AND HEALTH INSURANCE INFORMATION
(For the patient on the account)

Are you currently employed or were you employed at the time you had your medical service?
☐Yes ☐No
Does your employer offer Health Insurance to its employees? ☐Yes ☐No Are you covered by this health insurance? ☐Yes ☐No
If no, please explain why. _____

Is your spouse/domestic partner (or parent, if patient is a minor) currently employed or was employed at the time you had your medical service? ☐Yes ☐No
Does your spouse/domestic partner's (or parent, if patient is a minor) employer offer Health Insurance to its employees? ☐Yes ☐No
Are you covered by this health insurance? ☐Yes ☐No
If no, please explain why. _____

6. OTHER PROGRAMS
(For the patient on the account)

Have you applied for any of the following programs listed below within the last 12 months of this application? Please check any programs that apply.
☐ Medi-Cal ☐Healthy Families ☐Medicare ☐Basic Adult Care
☐ Victims of Violent Crime ☐State Disability

7. SUPPORTING DOCUMENTATION
(REQUIRED FOR ALL ADULTS LIVING IN HOUSEHOLD THAT CONTRIBUTE TO YOUR FINANCES) *[Family member defined as (1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not. (2) For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parents or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.*

Application may be denied if all documents are not provided. If a document is unavailable, please explain why.

- Tax return for the year in which the patient was first billed; or 12 months prior to when the patient was first billed
- OR
- Pay stubs within a 6 month period before or after the patient is first billed by the hospital for each Family member contributing to the household income

8. COMMENTS

Enter any additional information you want to state that is not reflected on this application.

9. SIGNATURE AND DATE (REQUIRED OF APPLICANT)
I certify that all information is true and complete, and hereby authorize John Muir Health to request a credit report and/or verify any of the above information as deemed necessary. I understand that incomplete applications, including an application missing a signature, may be denied. I agree to notify John Muir Health of any changes to my financial circumstances that may affect my eligibility for financial assistance.

Applicant Signature

_____

Date

_____

PLEASE RETURN APPLICATION AND ALL INFORMATION TO:

JOHN MUIR HEALTH
5003 COMMERCIAL CIRCLE
CONCORD, CA 94520
ATTN: SINGLE BUSINESS OFFICE

Your completed Patient Assistance Application along with the requested documentation will protect the account from further collection activity

Please remember to complete the entire application and send it with all the required documents that are listed in the cover letter.

Incomplete applications may not meet the qualification requirements of the program.

Please contact Customer Service at 925-947-3336 if you:

- Have any questions about the application
- Need assistance completing your application