Mee Memorial Healthcare System

Charity Care/Financial Assistance Application Form - confidential

Thank you for choosing Mee Memorial Healthcare System. This application is provided to

determine your eligibility for financial assistance. Mee Memorial offers financial assistance to

patients who have a family income that is 400% or less than the Federal Poverty Level and/or

have high medical costs. Financial Assistance is only available for services provided by Mee

Memorial Healthcare System. If you have any questions or need help filling out this

application, please call the Financial Assistance/Charity Care Department at (831) 386-7306.

IMPORTANT INFORMATION REQUIRED WITH APPLICATION

**Proof of Income (POI):** Please provide a copy of recent pay stubs or recent income tax returns

for all members of the patient family, as listed above. "Recent income tax returns" are tax

returns that document a Patient's income for the year in which the Patient was first billed or

12 months prior to when the Patient was first billed. "Recent paystubs" are paystubs within a

6-month period before or after the Patient is first billed by the hospital, or in the case of

preservice, when the application is submitted.

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

• Provide us information about your family; fill in the number of family members, which can include:

When patient is 18 years of age or older, family includes:

- Patient
- Spouse
- o Registered domestic partner
- o Dependent children under 21
- o Dependent children of any age if disabled

When patient is under 18 years of age, or is a dependent child of any age, family includes:

- o Patient
- o Patient's parent(s)
- o Patient's caretaker relative(s)
- o Other dependent children of the parent(s) or caretaker relative under 21 years of age





o Other child(ren) of the parent(s) or caretaker relative of any age if the child(ren) is disabled

- Provide us information about your family's gross monthly income (income before taxes and deductions). Applications without Proof of Income cannot be processed.
- Attach additional information if needed
- Sign and date the form

An incomplete application will be returned and will delay the application processing time.

Completed applications and required documentation may be returned to the Mee Memorial Healthcare System's Financial Counselors by:

Mail: Fax:

Mee Memorial Healthcare System Mee Memorial Healthcare System

Attn: Financial Counselor Attn: Financial Counselor

300 Canal Street Phone: 831-386-7306

King City, CA 93930 Fax: 831-385-7188

Every reasonable effort will be made to process your application promptly and once your application has been reviewed you will receive a letter confirming the outcome.



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## FINANCIAL ASSISTANCE APPLICATION

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lease fill out all infor	mation comple	tely. Please print al	I information. PLEASE N	OTE.				
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ast Name First Na		First Name	Middle Initial		nitial	Account Number		
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the patient is a mine	or, please list p	parent(s)/guardian(s	s) as applicar	nt and co-ap	pplicant.			
. APPLICANT (GU	ARANTOR) IN	FORMATION						
Relationship to Pat			nestic Partne	· 🗀 Pa	arent C	☐ Other		
Marital Status: 🔲	Single 🗆 l	Married	nestic Partne	· Divo	rced 🗆 S	eparated	☐ Widow	
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ast Name	First Name			Middle Initial		U.S. Citizen: ☐ Yes ☐ No		
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Street Address			City		State	County		Zip
Current Employer	5	Street Address		City		State	Position	•
If you are not wor	king, how lon	g have you been u	nemployed?	)				
. CO-APPLICANT I	INFORMATIO	N						
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ast Name	First Name			Middle Initial		U.S. Citizen: ☐ Yes ☐ No		
Date of Birth	No. of Dependents (other than self and co-applican		)	Ages of Dependents		Home Phone		
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Current Employer	5	Street Address		City	I	State	Position	<u>I</u>
If you are not wor	king, how lon	g have you been u	nemployed?	)			<u> </u>	

	4. OTHER COVERAGE (ALL ANSWERS PERTAIN TO	THE PATIENT)			Check appropriate answer
1.		rance? If yes, provide th	e following information:		☐ Yes
	Health Insurance Name:	Surance Name: Insurance Phone Number: No  Prs Name: Members/Patients Identification Number:  Date: Group/Employer Name: Group Number:			
	Subscribers Name:	Members/Pation	ents Identification Number:		
	Effective Date: Gro	up/Employer Name:	Group Numbe	er:	
2.	Is the patient eligible for a state m	nedical assistance progra	am? If yes, provide the followir	ng information:	☐ Yes
	Name of Program:	Patient	Identification Number		□ No
3.	Is the patient being treated for inju	rallent	s Compensation?		☐ Yes
0.	If yes, please provide the followin				□ res
	Adjusters Name:	Adjuster	rs Phone Number:		
	Injury Date:	 Claim/C	ase Number:		
4.	, ,		arty Liability such as an Auto I	nsurance	☐ Yes
	Company? If yes, provide the following				□ No
	Name of Auto Insurance or Attorn	ey:		-	
	Auto Insurance or Attorney Phone			-	
5.	Injury Date: Is the patient a Victim of Crime? I	f vos provido the fellowi	mber:	_	П V
5.	Name of Case Worker:				☐ Yes
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5.	INCOME INFORMATION				
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## SUPPLEMENTAL DOCUMENT

Please fill out all information completely. Please print all information.					
lease fill out all informat	ion completely. Please print all infor	mation.			
1 FAMILY INFORMATI	ON (Use additional supplemental do	ocument if you need to list more	family members)		
			,		
PLEASE PROVIDE NA	MES OF ALL PEOPLE TO BE COM	NSIDERED FOR FINANCIAL A	SSISTANCE)		
Last Name	First Name	Middle Initial	Account Number		
Last Name	First Name	Middle Initial	Account Number		
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