



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
- Registered domestic partner
- Dependent children under 21
- 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:

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



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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:

Mee Memorial Healthcare System
Attn: Financial Counselor
300 Canal Street
King City, CA 93930

Fax:

Mee Memorial Healthcare System
Attn: Financial Counselor
Phone: 831-386-7306
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

DATE OF APPLICATION: _____

Please fill out all information completely. Please print all information.

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may verify the information.

1. FAMILY INFORMATION (Use additional supplemental document if you need to list more family members) (PLEASE PROVIDE NAMES OF ALL PEOPLE TO BE CONSIDERED FOR FINANCIAL ASSISTANCE)

Last Name	First Name	Middle Initial	Account Number
Last Name	First Name	Middle Initial	Account Number
Last Name	First Name	Middle Initial	Account Number

If the patient is a minor, please list parent(s)/guardian(s) as applicant and co-applicant.

2. APPLICANT (GUARANTOR) INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widow

If you marked "Married", please complete Section 3.

Last Name	First Name	Middle Initial	U.S. Citizen: ☐ Yes ☐ No	
Date of Birth	No. of Dependents (Other than self and co-applicant)	Ages of Dependents	Home Phone ()	
Street Address		City	State	County Zip
Current Employer	Street Address	City	State	Position

* If you are not working, how long have you been unemployed?

3. CO-APPLICANT INFORMATION

Relationship to Patient: ☐ Spouse ☐ Parent

Last Name	First Name	Middle Initial	U.S. Citizen: ☐ Yes ☐ No	
Date of Birth	No. of Dependents (other than self and co-applicant)	Ages of Dependents	Home Phone ()	
Street Address		City	State	County Zip
Current Employer	Street Address	City	State	Position

* If you are not working, how long have you been unemployed?

4. OTHER COVERAGE (ALL ANSWERS PERTAIN TO THE PATIENT)		Check appropriate answer
1.	Does the patient have health insurance? If yes, provide the following information: Health Insurance Name: _____ Insurance Phone Number: _____ Subscribers Name: _____ Members/Patients Identification Number: _____ Effective Date: _____ Group/Employer Name: _____ Group Number: _____	☐ Yes ☐ No
2.	Is the patient eligible for a state medical assistance program? If yes, provide the following information: Name of Program: _____ County: _____ Patient Identification Number: _____	☐ Yes ☐ No
3.	Is the patient being treated for injuries covered by Workers Compensation? If yes, please provide the following information: Name of Work Comp Carrier? _____ Adjusters Name: _____ Adjusters Phone Number: _____ Injury Date: _____ Claim/Case Number: _____	☐ Yes ☐ No
4.	Is the patient being treated for injuries covered by Third Party Liability such as an Auto Insurance Company? If yes, provide the following: Name of Auto Insurance or Attorney: _____ Auto Insurance or Attorney Phone Number: _____ Injury Date: _____ Claim/Case Number: _____	☐ Yes ☐ No
5.	Is the patient a Victim of Crime? If yes, provide the following information: Name of Case Worker: _____ Case Workers Phone Number: _____ Claim/Case Number: _____	☐ Yes ☐ No

5. INCOME INFORMATION			
Monthly Income Sources	Applicant	Co-Applicant	Combined Monthly Income (Applicant + Co Applicant)
Employment Income	\$	\$	\$
Social Security	\$	\$	\$
Disability	\$	\$	\$
Unemployment	\$	\$	\$
Spousal Support	\$	\$	\$
Rental Property Income	\$	\$	\$
Investment Income	\$	\$	\$
Other[s] use these spaces	\$	\$	\$
	\$	\$	\$
Total Combined Monthly Income			

6. EXPENSE INFORMATION			
<i>We use this information to get a more complete picture of your financial situation.</i>			
Monthly Household Expense:			
Rent/Mortgage	\$	Medical Expenses	\$
Insurance Premiums	\$	Utilities	\$
Other Debt/Expenses	\$	<i>(child support, loans, medications, other)</i>	

7. SIGNATURE			
I certify that all information is valid and complete and hereby authorize Mee Memorial Healthcare System to request and/or verify any of the above information as deemed necessary.			
Applicant	Date	Co-Applicant	Date

SUPPLEMENTAL DOCUMENT

DATE OF APPLICATION: _____

Please fill out all information completely. Please print all information.

1. FAMILY INFORMATION (Use additional supplemental document if you need to list more family members) (PLEASE PROVIDE NAMES OF ALL PEOPLE TO BE CONSIDERED FOR FINANCIAL ASSISTANCE)			
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