



Complete application must be received no later than 30 calendar days after the date of discharge.

Or _____ (due date)

Dear Patient:

Attached is the requested application for the Patient Assistance Program offered by John Muir Health. This program is provided as part of our array of outreach services to the community we serve. Determination of eligibility for the program is based solely on a case by case basis. Eligible individuals may qualify for all or part of the cost of services they receive on the main campus of John Muir Health, Walnut Creek, John Muir Health, Concord or John Muir Behavioral Health.

Our program is designed to aide uninsured patients who need assistance in meeting the cost of their medical care incurred at one of our facilities. An “uninsured patient” means a patient who is responsible to pay a hospital bill that is not covered or discounted by any type of insurance or governmental program, or whose benefits under insurance have been exhausted. In order to qualify as an “uninsured patient”, the patient or the patient’s guarantor must verify that he or she is not aware of any right to insurance or government program benefits that would cover or discount the bill. Insurance in this case includes but is not limited to any HMO, PPO, California State funded programs, indemnity coverage, or consumer directed health plan. This program excludes elective procedures such as cosmetic surgery, reversal of previous tubal ligation or vasectomy, invitro fertilization and outpatient services.

This programs’ purpose is to help relieve the burden caused by unforeseen catastrophic occurrences for those of our patients who meet the program qualifications. It is not an insurance program for either continuing care, for costs incurred at other facilities, other providers of healthcare services or physician services. You will need to make separate arrangements with any healthcare provider which bills separately from our facility.

In order for your application to be considered you must demonstrate an effort to apply for medical coverage through the State of California or the County in which you reside. John Muir Health can refer you to the appropriate provider for assistance in completing and determining your eligibility for state or county funded programs. Please be advised that a credit check will be done for patients and/or their spouses, domestic partners, and also any other adult members living in the household.

If you have questions, please contact our Patient Financial Services department at (925) 947-3336.



HELP PROGRAM: PATIENT ASSISTANCE

The Patient Assistance Program is a self-funded program of John Muir Health. The purpose of the program is to offer financial assistance for medical bills incurred at our facilities only. It will not cover any amounts owed to any physicians or other providers who are not employees of the Medicare Centers.

All requested documents must be submitted in order for the application to be completed, and to be considered for approval.

SECTION I – GENERAL INFORMATION

PLEASE PRINT ALL RESPONSES

Patient Name _____
(First Name) (Last Name)

Address _____
(Street Number and Street Name) (Apt #)

(City) (State) (Zip)

Date of Birth: ____ / ____ / ____ Social Security Number ____ - ____ - ____

Contact Number: (____) _____ Cell Phone Number: (____) _____
(Other than cell phone)

1. Does the Patient have a Legal Conservator? Yes No

If “Yes” to question #1 above, please give the name and address of the Conservator:

Conservator Name: _____
(First Name) (Last Name)

Address: _____
(Street Number and Street Name) (Apt #)

(City) (State) (Zip)

Conservator’s Relationship to Patient: _____

2. Is the Patient under 18 years of age? Yes No

If “Yes” to question #2 above, please answer the following questions:

Name of Patient's Parent or Guardian: _____

Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____

Contact Number: (____) _____ Cell Phone Number: (____) _____
(Other than cell phone)

NOTE: ALL THE QUESTIONS BELOW REFER TO THE PATIENT IF THE PATIENT IS 18 YEARS OF AGE OR OLDER, OR TO THE PARENT/GUARDIAN IF THE PATIENT IS YOUNGER THAN 18 YEARS OF AGE.

SECTION II – EMPLOYMENT

3. Are you currently employed, or were you employed at the time you had your medical service?

Yes No

If "Yes" to question #3 above, please check one of the following boxes:

I am self employed My employer has less than 25 employees

My employer has 25 to 50 employees My employer has over 50 employees

4. Does your employer offer Health Insurance to its employees? Yes No

If "Yes" to question #4 above, do you have Health Insurance through your employer?

Yes No

5. Are you married or have a domestic partner? Yes No

If "Yes" to question #5 above, please answer the following questions:

6. Is your spouse/domestic partner currently employed, or was employed at the time you had your medical service? Yes No

If "Yes" to question #6 above, please check one of the following boxes:

Is self employed His/her employer has less than 25 employees

His/her employer has 25 to 50 employees His/her employer has over 50 employees

7. Does his/her employer offer Health Insurance to its employees? Yes No

If "Yes" to question #7 above, does he/she have Health Insurance through the employer?

Yes No

SECTION III – OTHER PROGRAMS

8. Have you ever applied for any of the following programs? (Please check any box which applies to you.)

MediCal Healthy Families MediCare State Disability

Commercial Insurance Basic Health Care Victims of Violent Crime

9. Have you ever qualified for any of the programs listed in question #8? Yes No

SECTION IV – FAMILY INFORMATION

10. Please list the name of all members of your family who are residing in your household:

Spouse/Domestic Partner: _____ Age: _____

Child: _____ Age: _____

Child: _____ Age: _____

Child: _____ Age: _____

Child: _____ Age: _____

(Attach additional sheets if necessary)

Other members of household:

Name: _____ Age: _____ Relationship to you: _____

(Attach additional sheets if necessary)

11. Are you living in the residence of your parent or another adult member of your family?

Yes No

If "Yes" to question #11 above, do you pay rent to that adult member?

Yes No

12. Do you rent a room or other space in your home to any other adult, including members of your family?
 Yes No
13. Do you receive all or some support from other adult members of the residence?
 Yes No
14. Are you receiving outside income for other expenses?
 Living School Medical bills Other
 Estimated Amount \$ _____/Month or \$ _____/Year
15. Are you currently attending school? Yes No
16. Does a parent or guardian claim you as a dependent on their income tax? Yes No
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SECTION V – INCOME ASSETS

17. Do you own any property? Yes No

If “Yes” to question #17 above, please list the addresses or location of your property (list location if the property has no specific address).

Property: _____

Property: _____

(Attach additional sheets if necessary)

18. Do you have/own any of the following? (Mark all that apply to you.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Home | <input type="checkbox"/> Rental Property | <input type="checkbox"/> Checking Account |
| <input type="checkbox"/> Credit Cards | <input type="checkbox"/> Savings Account | <input type="checkbox"/> Retirement Account |
| <input type="checkbox"/> Investment Account | <input type="checkbox"/> Stocks/Bonds | <input type="checkbox"/> Safe Deposit Box |
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SECTION VI – SUPPORTING DOCUMENTS

ALL DOCUMENTATION MUST BE PROVIDED, OTHERWISE YOUR APPLICATION WILL BE DENIED

Please attach the following documents to this application: (for all adults living in household)

- Tax Return for the most current year (need all pages)
 - Most current W-2's
 - Current pay stubs (including unemployment, disability & social security) – last three months
 - Bank Statements for all: Checking & Savings Accounts (Last three months)
Complete copies front and back.
 - Statements for all: Retirement and Investment Accounts. (Most recent quarter)
 - Proof you have applied for Medi-Cal – 1-800-709-8348
 - Proof you have applied for Basic Health Care – 1-800-771-4270
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SECTION VII – PATIENT STATEMENT

Please add any additional information you would like to have considered:

Signature of Person Applying

Date

SECTION VIII – ACCOUNT INFORMATION (For Internal Use Only)

Account Number: _____ Amount: \$ _____

Account Number: _____ Amount: \$ _____

Account Number: _____ Amount: \$ _____



PLEASE RETURN APPLICATION AND ALL INFORMATION TO:

**JOHN MUIR HEALTH
1400 TREAT BLVD
WALNUT CREEK, CA 94597
ATTN: PATIENT FINANCIAL SERVICES**

**Your completed Patient Assistance
Application along with the requested
documentation must be returned no later
than 30 days after the date of discharge.
Or _____ (due date)**

**If your application and documents are not received by the above deadline your request
will not be considered and patient assistance will be denied.**

**If you have any questions or need assistance filling out your application
please contact our Patient Financial Services department at 925.947.3336**