

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 over the last five months 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 below 400% of the Federal Poverty (FPL) 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	10
400% of FPL	\$54,360	\$73,240	\$92,120	\$111,000	\$129,880	\$148,760	\$167,640	\$186,520	\$205,400	\$224,280

Documentation Requirements:

- Current signed Tax Return **or** most recent W-2 and previous year signed Tax Returns, if current taxes are not filed
- Copy of pay stubs for the last two pay periods
- Proof of rent / mortgage payments for the past three months
- Most recent statements for all investment accounts
- The last three months bank statements, all pages – checking and savings
- School Transcript and Financial Assistance if applicable

In addition, if you do not have insurance:

- The patient is required 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 required 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.

We must receive this information within 30 days of this letter. NOTE: If your signed application and completed information is not received by the due date listed, John Muir Health is unable to consider your request for assistance and application will be denied.

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

Thank You.

1. PATIENT INFORMATION		
Last Name	First Name	DOB:

2. APPLICANT INFORMATION	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide the Conservator information below)				
Last Name	First Name	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> 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 finances? _____
Do you own your home? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you living in the residence of your parent or another adult? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you pay rent? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount of rent per month? _____
How do you pay your mortgage/rent? _____ Do you exchange work for rent/living expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain: _____
Do you receive all or some financial support from any adult members of the residence? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you receiving any of the following types of financial support? Please check all that apply. <input type="checkbox"/> Living expenses <input type="checkbox"/> Medical bills <input type="checkbox"/> Other _____ Estimated total amount of financial support: \$_____/month or \$_____/year

Do you currently receive financial assistance for attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No Total amount of financial support: \$ _____ /semester or \$ _____ / year
Do you currently receive government support? Please check all that apply. <input type="checkbox"/> Food Stamps <input type="checkbox"/> Housing Assistance <input type="checkbox"/> Payment of work injury <input type="checkbox"/> Disability <input type="checkbox"/> Welfare/WIC <input type="checkbox"/> Other (please specify): _____
Does your parent or guardian claim you as a dependent on their income tax? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did you file taxes last year? <input type="checkbox"/> Yes <input type="checkbox"/> No Was your adjusted gross income less than \$12,550? <input type="checkbox"/> Yes <input type="checkbox"/> No

5. EMPLOYMENT AND HEALTH INSURANCE INFORMATION <i>(For the patient on the account)</i>
Are you currently employed or were you employed at the time you had your medical service? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your employer offer Health Insurance to its employees? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you covered by this health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your spouse/domestic partner's (or parent, if patient is a minor) employer offer Health Insurance to its employees? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you covered by this health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain why. _____

6. OTHER PROGRAMS <i>(For the patient on the account)</i>
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. <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families <input type="checkbox"/> Medicare <input type="checkbox"/> Basic Adult Care <input type="checkbox"/> Victims of Violent Crime <input type="checkbox"/> State Disability

7. INCOME ASSETS <i>(For the person financially responsible for the account, if different than the patient)</i>
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"/> Savings Account <input type="checkbox"/> Credit Cards <input type="checkbox"/> Investment Account <input type="checkbox"/> Stocks/Bonds <input type="checkbox"/> Safe Deposit Box

**8. SUPPORTING DOCUMENTATION
(REQUIRED FOR ALL ADULTS LIVING IN HOUSEHOLD THAT CONTRIBUTE TO YOUR FINANCES)**

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

- Copy of signed Income Tax Return (1040 Form) that was last filed for every member of your household who filed taxes.
- Current pay stubs (last two pay periods)
- Proof of rent / mortgage payments for the past three months
- Most recent statements for all investment accounts
- The last three months bank statements, all pages – checking and savings
- School Transcript and Financial Assistance (if applicable)
- Copy of Social Security, Disability, Pension and/or Unemployment allotment letter (if applicable).
- Copy of Child Support court order or deposit slip (if applicable)

9. COMMENTS

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

10. 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 must be returned by
30 days of receipt of this letter**

**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.

**If your application and documents are not received by the above date, it will be
assumed you have decided not to continue with your application, and it will be closed.**

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

- **Have any questions about the application**
- **Need assistance completing your application**
- **Need more time to complete your application**