JOHN MUIR HEALTH

Patient Financial Assistance Program
John Muir Health Acct#: _____

Dear Patient:

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.

The enclosed application is for the John Muir Health Patient Financial Assistance Program. Any patient who is underinsured or uninsured and received services at one of John Muir Health's facilities (excluding Lab) can apply for the John Muir Health Patient Financial Assistance Program. To be eligible for this program, the patient will need to meet income qualifications based on the most recently published Federal Poverty Guidelines. 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. Acceptance into the program may also require that the patient apply for various health coverage options, including Medi-Cal, State Disability, Basic Health Care, Victim of Violent Crime or other related government-sponsored programs. Patients who have insurance which does not cover the services they received or have entirely exhausted their insurance benefits, are also considered eligible to apply for the John Muir Health Patient Financial Assistance Program. The John Muir Health Patient Financial Assistance Program covers accounts which are specifically listed on the application. It does not automatically cover future services.

The application and the documents listed in the application must be completed and submitted for the application to be considered complete. If an application and the required documents are not returned within thirty (30) days of the patient's request for an application, it will be assumed the patient is no longer interested in applying for the John Muir Health Patient Financial Assistance Program and the request will be closed.

If you have any questions regarding the application or the John Muir Health Patient Financial Assistance Program, please contact our Customer Service Department at: (925) 947-3336.
Thank you.

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

2. APPLICANT INFORMATION	**Marital Status** ☐ Married ☐ Single		**RELATIONSHIP TO PATIENT** ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** _____	
Last Name	**First Name**		**Date of Birth**	**Social Security**
Street Address (Do Not List PO Box)	**City**	**State**	**County**	**Zip**
How long at this address?	**Are you currently employed?** ☐ **Yes** ☐ **No**		**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 INFORMATION
Including yourself, how many people live in your house? _____ How many household members are 18 years of age or older? _____
Are you living in the residence of your parent or another adult? ☐ Yes ☐ No If "yes", do you pay rent? ☐ Yes ☐ No Amount of rent? _____
Do you receive all or some support from any adult members of the residence? ☐ Yes ☐ No
Are you receiving any other support for other expenses? ☐ Living ☐ School ☐ Medical bills ☐ Other Estimated Amount: $_____/month or $_____/year
Are you currently attending school? ☐ Yes ☐ No
Does your parent or guardian claim you as a dependent on their income tax? ☐ Yes ☐ No
Did you file taxes last year? ☐ Yes ☐ No (If no, please see Addendum 1) Was your adjusted gross income less than $5000? ☐ Yes ☐ No (If yes, please see Addendum 1)

5. EMPLOYMENT AND HEALTH INSURANCE INFORMATION

Are you currently employed or were you employed at the time you had your medical service?
☐ Yes ☐ No (If yes, 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

Does your employer offer Health Insurance to its employees?
☐ Yes ☐ No
If yes, why are you not insured with your employer? (Please explain below)

Is your spouse/domestic partner currently employed, or was employed at the time you had your medical service?
☐ Yes ☐ No (If yes, 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

Does his/her employer offer Health Insurance to its employees?
☐ Yes ☐ No
If yes, why is he/she not insured with the employer? (Please explain below)

6. OTHER PROGRAMS

Have you ever applied for any of the following programs listed below? ☐ Yes ☐ No
(If yes, please specify which program(s) below)

☐ Medi-Cal ☐ Healthy Families ☐ Medicare
☐ Basic Adult Care ☐ Victims of Violent Crime ☐ State Disability

7. INCOME ASSETS

Do you own any property? ☐ Yes ☐ No

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

☐ Home ☐ Rental Property ☐ Checking Account ☐ Savings Account
☐ Credit Cards ☐ Investment Account ☐ Stocks/Bonds ☐ Safe Deposit Box

8. SUPPORTING DOCUMENTATION (REQUIRED FOR ALL ADULTS LIVING IN HOUSEHOLD)

Application may be denied if all documents are not provided. Acceptable proof of income includes:
From applicant or guarantor (if the patient is a minor):

- Copy of **signed** Income Tax Return (1040 Form) from previous year for **every** member of your household who filed taxes.
- Current pay stubs (last two pay periods)
- 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 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

_____

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ADDENDUM 1: INCOME EXPLANATION	
Do you live in: ☐ Own home ☐ Rental apartment or house ☐ Rent a room ☐ Living with relatives ☐ Other (please specify): _____	
If living in the residence with a relative(s), do you pay rent to that adult member? ☐ Yes ☐ No If yes, how much is your rent? _____	
How do you pay mortgage/rent?	Please Explain:
Labor Exchange? ☐ Yes ☐ No (i.e., exchange work for rent/living expenses)	Please Explain:
Do you receive support from other adult members of the residence? ☐ Yes ☐ No	
Are you currently attending school? ☐ Yes ☐ No	
Does a parent or guardian claim you as a dependent on their income tax? ☐ Yes ☐ No	
Do you receive government support? ☐ Yes ☐ No (If yes, please check any box that applies to you) ☐ Food Stamps ☐ Housing Assistance ☐ Payment of work injury ☐ Disability ☐ Welfare/WIC ☐ Other (please specify): _____	
How do you pay for daily expenses (i.e., food, clothing, utilities, etc…)?	

JOHN MUIR HEALTH

PLEASE RETURN APPLICATION AND ALL INFORMATION TO:

JOHN MUIR HEALTH
5003 COMMERCIAL CIRCLE
CONCORD, CA 94520
ATTN: PATIENT FINANCIAL SERVICES

Your completed Patient Assistance Application along with the requested documentation must be returned by

_____ (due date)

Please remember to complete the entire application and send it with all the required documents.

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**