

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.



Patient Financial Assistance Program  
John Muir Health Acct#: \_\_\_\_\_

<b>1. PATIENT INFORMATION</b>		
Last Name	First Name	DOB:

<b>2. APPLICANT INFORMATION</b>	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	<b>RELATIONSHIP TO PATIENT</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		How long?	
Home Phone	Cell Phone		Other Contact	

<b>3. GENERAL INFORMATION</b>				
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	<b>RELATIONSHIP TO PATIENT</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____		
Street Address	Apt/Ste	City	State	Zip

<b>4. FAMILY INFORMATION</b>				
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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "yes", do you pay rent? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount of rent? _____				
Do you receive all or some support from any adult members of the residence? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you receiving any other support for other expenses?				
<input type="checkbox"/> Living				
<input type="checkbox"/> School				
<input type="checkbox"/> Medical bills				
<input type="checkbox"/> Other				
Estimated Amount: \$_____/month or \$_____/year				
Are you currently attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No				
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 (If no, please see Addendum 1)				
Was your adjusted gross income less than \$5000? <input type="checkbox"/> Yes <input type="checkbox"/> 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)

- |   |   |   |
|---|---|---|
| <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**

Do you own any property?  Yes  No

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)**

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**

\_\_\_\_\_

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



**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**