STANISLAUS SURGICAL HOSPITAL
A PHYSICIAN-OWNED FACILITY
1421 OAKDALE ROAD, MODESTO, CA 95355 | 209.572.2700

Date

Patient First Name Last Name
Address
City, State ZIP

Re: Notice of Charges and Request for Information Related to Insurance Coverage; Information Regarding Stanislaus Surgical Hospital's Charity Care

Dear Patient:

You recently underwent a surgical procedure at Stanislaus Surgical Hospital. Enclosed please find a statement of our charges for the care you received.

To date, we have not received proof of private or public health insurance coverage for the health care services you received at our facility. If you have health insurance coverage (including coverage under Medicare, Healthy Families Program, Medi-Cal, or other coverage), please notify us immediately so that we may appropriately bill for the services rendered.

If you do not presently have private or public health insurance, you may be eligible for health insurance coverage through the following programs:

Program:	**Application Information:**
• Medicare • CA Healthy Families Program • Medi-Cal • Covered California • CA Childrens' Services Program • Other State or County funded health coverage	http://www.ssa.gov/medicare/apply.html http://www.mrmib.ca.gov/mrmib/HFP.html); https://www.c4yourself.com/c4yourself/index.jsp); http://hbex.coveredca.com/ http://www.dhcs.ca.gov/services/ccs/Pages/apply.aspx

We would be happy to provide you with the applications for any of these health insurance programs. For assistance applying for health insurance coverage, please contact Stanislaus County Community Services Agency at (877) 652-0734. Covered California also has an enrollment assistance program. For more information regarding Covered California's enrollment assistance program, please visit http://hbex.coveredca.com/enrollment-assistance-program/.

Even if you have private or public health insurance (or if you do not have private or public health insurance), if you meet certain low to moderate income requirements, you also may be eligible for discounted or full charity care through Stanislaus Surgical Hospital's Charity Care Policy. A copy of a Financial Statement for Financial Assistance, which is necessary to apply for discounted or full charity care from our hospital, is attached. Should you desire to apply for discounted or charity care, please complete the enclosed financial statement, and return it to Christine Ybarra, Collections Supervisor at the address below. For questions regarding our Charity Care Policy or the application process, please contact:

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Christine Ybarra, Collections Supervisor
Stanislaus Surgical Hospital
1421 Oakdale Rd.
Modesto, CA 95355
(209) 232-2511 (phone)

Please note, a pending private or public health insurance application will not preclude your eligibility for our discounted or charity care under our Charity Care Policy.

Sincerely,

Christine Ybarra, Collections Supervisor

Enclosures

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Financial Statement for Financial Assistance

Name of Applicant		**Applicant's SS #** _____ **Co-Applicant's SS #** _____
Name of Co-Applicant	**Home Phone #**	**Date of Birth: Applicant** _____ **Co-Applicant** _____ **Children** _____ **Other** _____
Address		**Work Phone #: Applicant** _____ **Co-Applicant** _____

Optional: You do *not have to answer but it may aid in qualifying you for federal or state assistance program such as Medi-Cal* or *Disability.*

Are you pregnant? ☐ Yes ☐ No
Do you have children? ☐ Yes ☐ No
Are you disabled ☐ Yes ☐ No
If yes, how many? _____

PART 1 – INSURANCE

1. Do you presently have health insurance coverage through a private health insurer (including coverage offered through the California Health Benefit Exchange), Medicare, Medi-Cal, the Healthy Families Program, the California Children's Services program, or other state funded program? ☐ Yes ☐ No
2. If you answered **Yes** to Question 1, which insurance do you have?
   Please attach a copy of your proof of insurance to this Financial Statement.
3. If you answered **No** to Question 1, have you applied for health insurance coverage? ☐ Yes ☐ No
   a. If you answered **Yes** to Question 3, have you been denied for health insurance coverage? ☐ Yes ☐ No *If yes, please attach a copy of the denial to this Financial Statement.*

PART 2 – PLANNED EXPENSES and PAYMENTS

A - CASH EXPENSES	**Monthly**	**Next 12 months**	**Total Balance Due**
Food			
Clothing			
Medical: (list names of clinics and hospitals)			
Clinic			
Clinic			
Hospital			
Hospital			
Dentist			
Drugs			
Other			
Personal			
Beauty, Barber			
Laundry, Cleaning			
Allowances, Lunches			
Subscriptions			
Cash			
Other			
Household			
House Payments / Rent			

Fuel				
Electricity				
Telephone				
Cable TV				
Water and/or Sewer				
Home Repair and Maintenance				
Education: (Tuition, Books, Fees, Etc.)				
Gifts: (Holidays, Birthdays, Charity, Church, etc.)				
Recreation				
Eating Out				
Vacations & Trips				
Babysitters				
Activities				
Other				
Vehicles				
Payment 1: Year Make Model Loan #				
Payment 1: Year Make Model Loan #				
Gas & Oil				
Insurance				
License				
Maintenance & Repair				
Other Transportation: *Bus, Taxi, Train, etc.*				
Insurance				
Health				
Dental				
Life				
Other				
Taxes Payable: *Taxes you pay in for the month/year*				
Income				
Social Security				
Other				
Union or Professional Dues				
Child Care				
Child Support/Alimony (Paid Out)				
Planned Cash Purchases				
Other				
A. TOTAL CASH EXPENSES				
B – OTHER DEBT PAYMENTS (e.g. Credit Cards, Consumer Debt)				
Other Vehicles and Equipment				
Other: *Credit cards, Installment Loans, Personal debts, etc.*				
List				
B. TOTAL OTHER DEBT PAYMENTS				
PART 2 TOTAL (A + B)				

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PART 3 – FAMILY INCOME* * This portion must be completed for all applications for Charity Care (i.e., full and partial charity care)			
Applicant *Wages, Tips, Overtime, etc.* **Employer**_____			
Co-Applicant *Wages, Tips, Overtime, etc.* **Employer**_____			
Business Income			
Other *(Social Security, Retirement, Alimony, Child support, VA, Welfare, Other income, etc.)* *List:*			
PART 3 TOTAL			

PART 4 – ASSETS** * This portion must be completed for all applications for *full* Charity Care				
i. Checking Account:	**Bank:**	**Address**	**Acct #:**	**Balance:**
ii. Savings Account:	**Bank:**	**Address**	**Acct #:**	**Balance:**
iii. Other Accounts:	**Bank:**	**Address**	**Acct #:**	**Balance:**
iv. CDs Stocks, Bonds (*exclude retirement plans*)			**Acct #**	**Value:**
v. Total Other Assets: (Real Estate, Machinery, etc.)				**Value:**
vi. *Less:* first $10,000 in cash assets				(10,000)
vii. Subtotal				
viii. 50% (of Subtotal above)				
PART 4 TOTAL: if negative, enter "0"				

PART 5 – SUMMARY			
A. Total Income: *Part 3 total*			
B. Assets: *Part 4 total*			
C. Total Expense and Debt Payments: *Part 2 total*			
D. *Balance (A + B – C)*			
E. 50% of D (*minimum patient responsibility*)			
F. Medicare Allowable			
G. Lesser of E and F			

The information stated in this application is correct to the best of my knowledge. You are authorized to check my credit and employment history and to answer questions about your credit experience with me.
You are further authorized to disclose any information contained herein and other information obtained by you with regard to my credit and employment history to third parties, solely for the purpose of obtaining financing for payment of any indebtedness that I might owe you.
By signing this agreement I am promising to cooperate with the hospital staff and provide adequate information in a timely matter to get my bill resolved.

Signature of Applicant **Date**

Signature of Co-Applicant **Date**