APPLICATION FOR SPONSORED CARE OR DISCOUNT PAYMENT PROGRAM

This is an application for the Sponsored Care and Discount Payment programs.

To be considered for financial assistance, a completed application must be submitted to our office no later than 240 days from the original bill date. Due to the length of time allowed to submit an application, late submissions will not be considered.

Please be sure to attach required documentation as indicated on the application.

This program is the payer of last resort and should only be accessed after all other means of payment have been exhausted. This means that you need to apply for any and all government programs for which you may be eligible, such as Medicare, Medi-Cal and the California Health Benefit Exchange. Enrollment Counselors are available at Community Hospital to help you through the application process for most government programs.

If you apply and are deemed eligible by Community Hospital for Sponsored Care or the Discount Payment Program, you will be notified of the discount amount for which you have been approved. This program does not cover fees and charges from other providers (including physicians) for which Community Hospital does not bill. It also does not cover transportation (i.e. ambulance).

If you have questions regarding the completion of your application please call us at any of these numbers:

For information prior to care or services:
Social Services
(831) 622-2722

For information during care:
Patient Access
(831) 625-4910

For information after care:
Patient Business Services
(831) 625-4922
APPLICATION TO DETERMINE SPONSORED CARE OR DISCOUNT PAYMENT PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if independent and age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for Community Hospital's Sponsored Care Program or Discount Payment Program. The term "applicant" means the patient for whom Community Hospital provided or will provide medical services. Please type or print clearly.

A. APPLICANT INFORMATION

1. Name of applicant (Last, first, middle): ____________________________

2. Any other name the applicant is known by: ____________________________

3. Date of birth (Month, day, year): ____________________________

4. Social Security number: ____________________________

5. Residence address:

   Number and street (do not use P.O. Box) __________________________________ 
   City ____________________ State ________ Zip ________

6. Mailing address (if different from residence):

   Number and street (do not use P.O. Box) __________________________________
   City ____________________ State ________ Zip ________

7. Daytime phone number: ____________________ 8. Evening phone number: ____________________

9. Message phone number: ____________________

10. What language do you speak at home?: ____________________

11. Type of service provided or requested: ____________________

12. The Sponsored Care and Discount Payment programs require submission of the following documentation:

   • Completed application form
   • Proof of income:
     ○ Copy of signed tax return from the most recent tax year
     ○ Pay stubs from the past 3 months, for all members of the family
     ○ Copy of most recent W2 form (Sponsored Care Program only) for the following family members: spouse, domestic partner, dependent children, and parent if applicant is a minor.
   • Proof of medical insurance or eligibility for California Health Benefit Exchange
   • Medi-Cal program linkage determination, if applicable
   • Health insurance denial, if applicable

You may be asked to provide additional documentation, including but not limited to the following:

   • Proof of out-of-pocket medical, dental, pharmacy, and insurance premium expenses, such as receipts
   • Additional supporting documentation of lack of income
B. PARENT/LEGAL GUARDIAN INFORMATION (Applicants age 18 or older or emancipated minors skip items 13 through 18)

13. Name(s) of parent or legal guardian: ______________________________ Relationship: ______________________________

14. Residence address:

   Number and street (do not use P.O. Box) ______________________________ City __ State __ Zip __

15. Mailing address (if different from residence):

   Number and street (do not use P.O. Box) ______________________________ City __ State __ Zip __

16. Daytime phone number: ______________________________ 17. Evening phone number: ______________________________

18. Message phone number: ______________________________

C. HEALTH INSURANCE INFORMATION

19. Does the applicant have Medi-Cal? If yes, what is the applicant’s Medi-Cal ID number?

20. Does the Applicant have other health insurance including but not limited to:
   - Third Party insurance coverage
   - Eligibility or active coverage with the California Health Benefit Exchange

21. Total paid out of pocket medical expenses for the past 12 months $_________ attach proof of payment

D. INCOME INFORMATION (Report income for the following family members: spouse, domestic partner, parent, and dependent children. Attach additional sheets if necessary.)

22. Number of family members (including applicant) in your home you can claim on your income tax: ____________

<table>
<thead>
<tr>
<th>Name of family member</th>
<th>Employer</th>
<th>Student status Yes or No Full-time or Part-time</th>
<th>Gross income for last 12 months</th>
<th>Income most recent tax year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
E. ASSET INFORMATION (Complete this section only if you are applying for the Sponsored Care Program)

Report the current value of your monetary assets. Attach additional sheet if necessary.

*Supporting documents may be required.*

<table>
<thead>
<tr>
<th>Value</th>
<th>Account number</th>
<th>Name/address of institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checking account</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Savings account</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certificate of deposit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brokerage account</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-tax-deferred securities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and investments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precious metals/jewelry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assets held in trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other monetary assets</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I am applying for the hospital's Sponsored Care or Discount Payment Program as indicated above.

I understand that failure to provide requested information by the due date will result in denial of my application.

I certify that I have read and understand the information on this application.

I certify that the information I have given on this form is true and correct.

I give my permission for Community Hospital of the Monterey Peninsula to contact any healthcare provider regarding my medical care and treatment.

I understand and agree that a credit report will be run on all Sponsored Care requests. Other verifications such as employment and property ownership searches may be conducted at the hospital's discretion.

Additional comments: ____________________________________________________________

__________________________________________________________

Applicant’s signature ___________________________ Today’s date __________________