Application for Financial Assistance / Charity Care

Thank you for choosing Mee Memorial Healthcare System as your healthcare provider. This application is provided to you to determine if you meet the Federal requirement for Charity Care at Mee Memorial Healthcare System. This application must be filled out completely. An incomplete application will be returned and will delay the application processing time. If you have any questions or need help filling out this application, please call the Financial Assistance/Charity Care Department at (831) 386-7306.

(Optional) Please include with your application the following documents:

- A copy of your Federal Income Tax return for the two (2) most recent years.
- A copy of your Driver's License or State Identification.
- Most recent three (3) months check stubs or a letter from your employer showing proof of your wages.
- If you are self-employed, a copy of your company's Income Statement.
- Written determination of ineligibility for Medicaid from the Department of Social Services.
- Most recent three (3) month's bank statements.

When determining eligibility for hospital charity care assistance, a spouse's income and assets must be used for an adult. Parent(s) income and assets must be used for a minor child.

(Optional) Additional Application Instructions:

1. If the patient is a minor, the guarantor or guardian must provide his/her information.
2. If the patient is deceased, the executor of the estate or the legal guardian must provide his/her information or a death certificate.
3. One application per patient.
4. The application is good for a period of three (3) months in the current year from date of service.
5. If you are unemployed and live with someone, please provide a letter from the person showing proof of support.
6. If you are unemployed, please provide copy of your unemployment compensation warrant.
7. Completed application must be returned to us with fourteen (14) days of issue.

Section 1 – Personal Information Today's Date _____/_____/_____

Date of Service ____/____/____ Date of Service ____/____/____ Date of Service ____/____/____

Patient Name (Last, First, MI) Social Security Number(Optional)

Street Address of Patient City, State, Zip Code

Patient Date of Birth ___/___/___U.S. Citizen (Optional) Yes No CA Resident (Optional) No ☐ Yes ☐

( )
Telephone Number Name of Guarantor (if other than patient - (Optional))

Family Size:

_____

Names: Age: Relationship:

Employed (Optional)
Yes No Job Title Length of Employment

( )
Employer's Name Contact Person Telephone Number

Employer's Street Address City, State, Zip Code

Does your employer offer medical coverage? ☐ Yes ☐ No

If yes, reason why you are not covered?

_____

Mee Memorial Healthcare System
QUALITY CARE, CLOSE TO HOME.

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8530.001 (Rev. 1/12/23 – FINAL)

Section 2 – Source of Income		Weekly	Monthly	Yearly
Salary before deductions (include Military)	$ _____	○	○	○
Public Assistance	$ _____	○	○	○
Social Security (and/or VA benefits)	$ _____	○	○	○
Alimony / Child Support	$ _____	○	○	○
Pension Payments	$ _____	○	○	○
Rental Income	$ _____	○	○	○
Other Monetary Support: _____	$ _____	○	○	○

Grand Total of Income: $

Section 3 – Certification by Applicant

I, _____, understand that the information that I submit is subject to verification by ***Mee Memorial Healthcare System***, its employees, and the Federal/State government. Willful misrepresentation of these facts will make me liable for all hospital charges and subject to civil penalties.

As requested by ***Mee Memorial Healthcare System***, I certify that I have applied for Medicaid through the State of California and have attached with this application a copy of the denial letter.

I certify that the above information regarding my family size, income, and assets is true and correct.

I understand that it is my responsibility to advise ***Mee Memorial Healthcare System*** of any changes in status in regards to my income or assets while this application is in process.

_____ _______________

Signature of Applicant (Patient or Guarantor) Date

Please attach copies of all proof of income and assets with this application.

Not part of the permanent medical record.