

**RADY CHILDREN’S HOSPITAL – SAN DIEGO  
FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS**

**Instructions**

As part of our commitment to serve the community, Rady Children’s Hospital – San Diego elects to provide financial assistance to patients/guarantors who are financially indigent or medically indigent and satisfy certain requirements.

To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please provide the following information and copies of information with your financial assistance application:

1. Statement of Financial Condition
2. Documents to verify income:
3. Medi-cal Notice of Action

<b>Please provide <i>one or more</i> of the following:</b>	<b>Please provide a copy of <i>one</i> of the following:</b>
<ul style="list-style-type: none"> <li>A. IRS Form W-2, Wage and Earnings Statement for all household earnings;</li> <li>B. Last two pay check stubs for all household earnings; and/or</li> <li>C. Bank statement that contains income information.</li> </ul>	<ul style="list-style-type: none"> <li>A. Governmental Assistance, Social Security or Workers’ Compensation; or</li> <li>B. Unemployment compensation letter; or</li> <li>C. Income tax return for previous year.</li> </ul>

In the event income verification is unavailable, please contact our office for further instructions. Applications without income verification are considered incomplete and will not be processed. For assistance in completing this application, please contact Rady Children’s Hospital – San Diego at 858-966-4912, Monday through Thursday from 8:00 a.m. to 6:30 p.m., and Friday from 8:00 a.m. to 4:30 p.m. Please return the application and verification of income documents within 14 calendar days to:

Financial Counseling Department  
Rady Children’s Hospital – San Diego  
3020 Children’s Way, MC 5055  
San Diego, California 92123-4282

Please note that physicians providing services at Rady Children’s Hospital – San Diego are not employees of Rady Children’s Hospital – San Diego. You will receive separate bills from your private physician and from other physicians whose services you required (e.g. surgeon, radiologist, pathologist, hospitalist, etc.). The Financial Assistance Application does not apply to any amounts due by you for physician services. For questions regarding their bills, or to make payment arrangements for physician services, please contact the individual physician’s office.

We will notify you of your eligibility following receipt and review of all necessary information. The notification will be mailed to the mailing address you have provided on the Financial Assistance Application.

**STATEMENT OF FINANCIAL CONDITION**

PATIENT NAME \_\_\_\_\_ ACCOUNT NO. \_\_\_\_\_  
 GUARANTOR NAME \_\_\_\_\_  
 GUARANTOR NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 \_\_\_\_\_  
 PHONE \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY STATUS:** List all dependents in the household

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**EMPLOYMENT AND OCCUPATION**

Employer: \_\_\_\_\_ Position: \_\_\_\_\_  
 Contact Person and Telephone: \_\_\_\_\_  
 If Self-Employed, Name of Business: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Position: \_\_\_\_\_  
 Contact Person and Telephone: \_\_\_\_\_  
 If Self-Employed, Name of Business: \_\_\_\_\_

**CURRENT MONTHLY INCOME**

	Guarantor	Guarantor
Gross Pay (before deductions)	_____	_____
<i>Add</i> Income from Operating Business (if Self-employed)	_____	_____
<i>Add</i> Other Income:		
Interest and Dividends	_____	_____
From Real Estate or Personal Property	_____	_____
Social Security	_____	_____
Other (specify):	_____	_____
Alimony or Support Payments Received	_____	_____
Subtract Alimony, Support Payments Paid	_____	_____
Equals Current Monthly Income	_____	_____

FAP application, eligibility worksheets and correspondence for Center Policy Manual, CPM 7-11 "Charity Care, Financial Assistance, and Billing & Collection"

Total Monthly Income (combine both Guarantors) \_\_\_\_\_

**FAMILY SIZE**

Total Family Members      Add patient, guarantors and dependents from above.      \_\_\_\_\_

By signing this form, I agree to allow Rady Children’s Hospital – San Diego to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I am also required to provide the documents outlined in the RCHSD Financial Assistance Application Instructions within 14 days.

\_\_\_\_\_  
Signature of Guarantor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guarantor

\_\_\_\_\_  
Date

**RADY CHILDREN’S HOSPITAL – SAN DIEGO  
INSTRUCCIONES PARA SOLICITAR AYUDA ECONÓMICA**

**Instrucciones:**

Como parte de nuestro compromiso para servir a la comunidad, Rady Children’s Hospital – San Diego (RCHSD) ha decidido proporcionar ayuda financiera a pacientes / fiadores que tienen necesidades médicas y que son personas de bajo ingreso, sin seguro médico, o que de otra forma no puedan pagar el cuidado médico necesario basado en sus necesidades económicas, como se define por las Normas Federales del Ingreso de Pobreza (*Federal Poverty Income Guidelines*). La ayuda económica no se considera como un sustituto de la responsabilidad personal, y se espera que los pacientes / fiadores cooperen con el proceso llevado a cabo por RCHSD para obtener ayuda financiera, así como que contribuyan a los gastos de su atención médica, en base a su habilidad individual de pago.

Para determinar si el paciente / fiador llena los requisitos para recibir la ayuda económica necesitamos obtener cierta información financiera. Su cooperación nos permitirá darle toda la debida consideración a su solicitud para dicha ayuda. Haga el favor de proporcionar la siguiente información, así como copias de los documentos requeridos junto con su solicitud para ayuda económica.

- 1. Estado de condición financiera y**
- 2. Documentos para verificar su ingreso:**
- 3. Carta de elegibilidad de Medi-cal (Notificación de Acción)**

<b>Por favor proporcione <i>uno o más</i> de lo siguiente:</b>	<b>Por favor proporcione una copia de <i>uno</i> de los siguientes:</b>
<ul style="list-style-type: none"> <li>D. Formulario W-2 IRS, estado de ingresos y de todas las personas asalariadas que viven en la casa;</li> <li>E. Los dos últimos talonarios de ingresos de todas las personas asalariadas que viven en la casa; y/o</li> <li>F. Estados de cuenta bancarios con información de ingresos.</li> </ul>	<ul style="list-style-type: none"> <li>D. Asistencia gubernamental, Seguro Social, o Compensación por accidentes laborales; o</li> <li>E. Carta de compensación por desempleo; o</li> <li>F. Declaración de impuestos del año anterior.</li> </ul>

En el caso de que no se disponga de una verificación de ingresos, póngase en contacto con nuestra oficina para recibir instrucciones adicionales. Las solicitudes que no vengán acompañadas de una verificación de ingresos se considerarán incompletas y no serán procesadas. Para solicitar ayuda para completar esta solicitud, llame Rady Children’s Hospital – San Diego al 858-966-4912, de lunes a jueves de 8:00 a.m. a 6:30 p.m., y viernes de 8:00 a.m. a 4:30 p.m. **Por favor, envíe la solicitud y la documentación de verificación de ingresos en un plazo de 14 días calendario, a:**

FAP application, eligibility worksheets and correspondence for Center Policy Manual, CPM 7-11 “Charity Care, Financial Assistance, and Billing & Collection”

Financial Counseling Department  
Rady Children's Hospital – San Diego  
3020 Children's Way, MC 5055  
San Diego, California 92123-4282

Tome nota de que los médicos que proporcionan servicios en Rady Children's Hospital – San Diego no son empleados de Rady Children's Hospital – San Diego. Usted recibirá una factura por separado de su médico y de otros médicos cuyos servicios usted haya solicitado (esto es, cirujano, radiólogo, patólogo, pediatra especialista en niños hospitalizados, etc.). La Solicitud de Ayuda Económica no cubre ninguna cantidad pendiente que usted deba por honorarios médicos. Para preguntas relacionadas con dichas facturas o para hacer arreglos de pago por honorarios médicos, comuníquese al consultorio del médico en cuestión.

Le notificaremos acerca de su elegibilidad después de recibir y revisar toda la información necesaria. La notificación se enviará por correo al domicilio que usted nos ha proporcionado en su Solicitud de Ayuda Económica.

To be completed by office  
Patient Account Number: \_\_\_\_\_

## DECLARACIÓN DE CONDICIÓN FINANCIERA

NOMBRE DEL PACIENTE \_\_\_\_\_  
NOMBRE DEL FIADOR \_\_\_\_\_  
NOMBRE DEL FIADOR \_\_\_\_\_  
DOMICILIO \_\_\_\_\_  
TELÉFONO \_\_\_\_\_

**CONDICIÓN FAMILIAR:** Enumere todos los dependientes que viven en la casa

<u>Nombre</u>	<u>Edad</u>	<u>Parentesco / Relación</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### EMPLEO Y OCUPACIÓN

Empleador: \_\_\_\_\_

Posición: \_\_\_\_\_

Nombre y teléfono de persona a contactar:  
\_\_\_\_\_

Si trabaja por cuenta propia, nombre del  
negocio: \_\_\_\_\_

Empleador del cónyuge: \_\_\_\_\_

Posición: \_\_\_\_\_

Nombre y teléfono de persona a contactar:  
\_\_\_\_\_

Si trabajo por cuenta propia, nombre del negocio:  
\_\_\_\_\_

**INGRESO MENSUAL ACTUAL**

	<b>Fiador</b>	<b>Fiador</b>
Ingreso bruto (antes de deducciones)	_____	_____
Agregue Ingreso de negocios activos (si trabaja por su cuenta)	_____	_____
Agregue Otros ingresos:		
Intereses y dividendos	_____	_____
De bienes raíces o de propiedad personal	_____	_____
Seguro Social	_____	_____
Otros (especifique):	_____	_____
Pensión alimenticia o pagos de manutención recibidos:	_____	_____
Substraiga Pensión alimenticia, pagos de manutención	_____	_____
Igual a Ingreso mensual actual	_____	_____
<b>Ingreso mensual total</b> (combine ambos fiadores)	\$ _____	_____

**COMPONENTES FAMILIARES**

Total de miembro en la familia    Agregue al paciente, fiador y a los dependientes de arriba \_\_\_\_\_

**CANTIDAD DE PERSONAS**

Número de las personas que viven en la casa: \_\_\_\_\_

**OTROS BIENES RAICES / PROPIEDAD**

	<b>Sí</b>	<b>No</b>
¿Es el propietario de su casa?	<input type="checkbox"/>	<input type="checkbox"/>
	Sí	No
¿Es propietario de otro bien raíz/ propiedad?	<input type="checkbox"/>	<input type="checkbox"/>
Si es así, enumérelos:		

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Al firmar este formulario, estoy de acuerdo en que Rady Children’s Hospital – San Diego revise mi historial de empleo y de crédito con la finalidad de determinar mi elegibilidad para un descuento económico. Entiendo que también necesitaré presentar los documentos señalados en las instrucciones de la Solicitud de Ayuda Económica de RCHSD en un plazo de 14 días.

\_\_\_\_\_

Firma del Fiador

\_\_\_\_\_

Fecha

\_\_\_\_\_

Firma del Fiador

\_\_\_\_\_

Fecha

# FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION WORKSHEET

Patient Name: \_\_\_\_\_  
Account Number(s): \_\_\_\_\_

Special Considerations/Circumstances:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

	Yes	No
Does patient have insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Is patient eligible for Medi-Cal?	<input type="checkbox"/>	<input type="checkbox"/>
Is patient eligible for other Government Programs?	<input type="checkbox"/>	<input type="checkbox"/>

If eligibility exists for above programs, patient will not generally be eligible for charity care (unless care was provided when the patient's eligibility status was not yet established).

Is patient self-pay?  Yes  No

### Charity/Financial Assistance Calculation

Total Combined Current Monthly Income (from Statement of Financial Condition) \$ \_\_\_\_\_

Total Annual Income \$ \_\_\_\_\_

Income Verification Code \_\_\_\_\_  
Family Size (from Statement of Financial Condition) \_\_\_\_\_

Total Medical Expense Liability \$ \_\_\_\_\_

### Qualification for Charity Care/Financial Assistance

1. Is total annual household income equal to or less than 200% of the Federal Poverty Guidelines?  
(See Financial Assistance Eligibility Guidelines – Schedule A) **Circle one**

**YES**      Approved for 100% financial assistance; only co-payment on Schedule A is required

**NO**      Does not qualify for assistance. Continue to step 2.

2. Is total annual household income equal to or less than 400% (between 201% to 400%) of the Federal Poverty Guidelines? (See Financial Assistance Eligibility Guidelines – Schedule A) **Circle one**

**YES**

Total Annual Income is greater than \_\_\_% and less than \_\_\_% of the Federal Poverty Guidelines. Patient/guarantor qualifies for partial charity care discount as pursuant to Financial Assistance Eligibility Guidelines (Schedule A) and, therefore, patient/guarantor is eligible for one of the following levels on the discounted Private Pay Fee Schedule:

- Up to 300 percent of FPL                      75% discounted rate column B
- Up to 400 percent of FPL                      50% discounted rate column C

(Note: All self-pay patients with incomes greater than 400 percent of the FPL will be offered a 25% discount off of charges, column D, as part of our prompt pay program. These patients should not require a financial assistance application unless their medical expense liability is unwieldy and should be considered for catastrophic eligibility.)

**NO**

Continue to worksheet to assess possible catastrophic eligibility – Upper Limit Patient Liability Worksheet.

**Charity Care/Financial Assistance Discount**

Determined discount level \_\_\_\_\_%  
Balance Due from discounted Private Pay Fee Schedule \$ \_\_\_\_\_

**Worksheet completed by:**

_____	_____	_____
Employee name (please print)	Title	Phone
_____	_____	
Employee signature	Date	

---

Approved by: _____	Date: _____
Approved by: _____	Date: _____
Approved by: _____	Date: _____
Approved by: _____	Date: _____
Approved by: _____	Date: _____

**Notes:**

**Approval Matrix**

Up to \$5,000	Financial Counselor or Biller/Follow Up Collector PFS Supervisor or Inpatient Admissions/Financial Counseling Supervisor
Up to \$10,000	
Up to \$25,000	Patient Access Director or PFS Manager PFS Director or Revenue Cycle Director CFO or COO
Up to \$50,000	
Up to \$100,000	

Income Verification Codes

1	IRS Form W-2, Wage and Earnings Statement	6	Bank statements
2	Pay check remittance	7	Written attestation of guarantor
3	Tax returns	8	Verbal attestation of guarantor
4	Social Security, Work Comp or Unemployment Comp letter	9	Government Program
5	Telephone verification by employer	10	Other

For Catastrophic Eligibility only:

## Upper Limit Patient Liability Worksheet

PATIENT NAME \_\_\_\_\_  
ACCOUNT NO. \_\_\_\_\_  
GUARANTOR NAME \_\_\_\_\_  
GUARANTOR NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PHONE \_\_\_\_\_

### Is the patient eligible for charity care?

- \_\_\_\_\_ Yes (*Refer to charity care policy and Financial Assistance Eligibility worksheet for further instructions.*)  
\_\_\_\_\_ No (*Complete form to determine applicable ceiling.*)

- A. Total patient liability: \_\_\_\_\_  
B. Total annual household income: \_\_\_\_\_  
C. Upper limit charge for ceiling for patient (B x \_\_\_\_\_%)\*: \_\_\_\_\_  
D. **Amount to be billed:** \_\_\_\_\_  
(*If A < C, billed amount is A. If A > C, billed amount is C.*)

### Remaining Balance Write – Off:

- \_\_\_\_\_ Charity Care  
\_\_\_\_\_ Bad Debt  
\_\_\_\_\_ Other (Specify: \_\_\_\_\_)

### Worksheet completed by:

\_\_\_\_\_  
Employee name (please print) Title Phone  
\_\_\_\_\_  
Employee signature Date

---

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_  
Approved by: \_\_\_\_\_ Date: \_\_\_\_\_  
Approved by: \_\_\_\_\_ Date: \_\_\_\_\_  
Approved by: \_\_\_\_\_ Date: \_\_\_\_\_  
Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Upper limit charge:** 20% of annual household income for guarantors less than 300% of FPL; or  
30% of annual household income for guarantors greater than 300% of FPL.

FAP application, eligibility worksheets and correspondence for Center Policy Manual, CPM 7-11 "Charity Care, Financial Assistance, and Billing & Collection"

<Date>

<Guarantor>

<Address>

<City, State ZIP>

RE:

Account Number:

Balance Due:

Dear <Guarantor>:

Thank you for choosing Rady Children’s Hospital – San Diego. We appreciate you taking the time to complete and return the Application for Financial Assistance. Rady Children’s Hospital San Diego uses this information to determine your eligibility for reduced fee under the Rady Children’s Hospital Charity Care Financial Assistance program.

In reviewing your Application for Financial Assistance, we are happy to inform you that you have been approved for a <enter discount here>% discount , which reduces the balance due to \$<remaining balance>. Our determination was based upon your income, household size and Federal Poverty Guidelines.

If you have any questions about our decision, please call Customer Service at \_\_\_\_\_. Thank you.

Sincerely,

Name

Title (Financial Counselor)

<Date>

<Guarantor>

<Address>

<City, State ZIP>

RE:

Account Number:

Balance Due:

Dear \_\_\_\_\_ :

Thank you for choosing Rady Children's Hospital – San Diego. We appreciate you taking the time to complete and return the Application for Financial Assistance. Rady Children's Hospital – San Diego uses this information to determine your eligibility for a reduced fee under the Rady Children's Hospital Charity Care Financial Assistance program.

In reviewing your Application for Financial Assistance, we have determined that you are not eligible for charity care or financial assistance under our policy. Our determination was based upon your income, household size and Federal Poverty Guidelines.

If you have any questions about our decision, please call Customer Service at \_\_\_\_\_.

Sincerely,

Name

Title (Financial Counselor)

<Date>

<Guarantor>

<Address>

<City, State ZIP>

RE:

Account Number:

Balance Due:

Dear <Guarantor>:

Thank you for choosing Rady Children’s Hospital – San Diego. We understand that you may be eligible for our Charity Care Financial Assistance program. In order to determine your eligibility, we need the following documents be sent to us within 14 days:

Rady Children’s Hospital – San Diego uses this information to determine your eligibility for a reduced fee under the Rady Children’s Hospital Charity Care Financial Assistance program. If you do not send us this information within 14 days, then your application may be denied for financial assistance. If you can provide the documents at a later date, then your application will be reconsidered for financial assistance.

If you need assistance with the application or the required documents, please call our Customer Service Representatives at \_\_\_\_\_ with any questions. Thank you.

Sincerely,

Name

Title (Financial Counselor)

<Date>

<Guarantor>

<Address>

<City, State ZIP>

RE:

Account Number:

Balance Due:

Dear <Guarantor>:

On \_\_\_\_\_, we sent you a letter requesting copies of documents as part of your Application for Charity Care Financial Assistance. Rady Children's Hospital – San Diego requires these documents to determine your eligibility for a discount under our Charity Care Financial Assistance program.

Since we have not received the requested information within 14 days, your request for financial assistance is denied. If you can provide the documents at a later date, then your application will be reconsidered for financial assistance at that time.

If you have any questions about our decision, please call Customer Service at \_\_\_\_\_.

Sincerely,

Name

Title (Financial Counselor)