Patient Name:
Patient Address:

Patient Number:
Date (s) of Service:

CATALINA ISLAND HEALTH
An affiliate of UCI Health

Financial Assistance / Charity Screening Form

Thank you for choosing Catalina Island Health as your healthcare provider. Based upon our financial screening, you do not have any healthcare insurance to pay for your visit. Catalina Island Health offers Financial Assistance/Charity Care for our uninsured and underinsured patients. Patients whose income is at or below 400% of the federal poverty level will be eligible for some kind of assistance. We are including our financial assistance/charity care application for your review.

All patients must apply for Medi-Cal before charity care funds are considered.

To determine your eligibility for financial assistance, please complete this enclosed application and provide copies of the following list of documents to our office as soon as possible. You are financially responsible for the outstanding balance until your application is reviewed and approved or denied.

- ☐ Last 2 months paystubs
- ☐ Notarized statement of in-kind support
- ☐ Previous year or current year tax returns
- ☐ Approval or denial letter from Medi-Cal
- ☐ Last two months of complete bank statements
- ☐ Proof of high medical cost (see below for explanation)
- ☐ Other: _____

If your balance represents your liability after your insurance has paid, you must provide proof of high-cost medical bills. High-cost medical bills means all medical liabilities you have paid in the last 12 months; that equals 10% or more of your annual household income.

If you have any questions or need assistance completing our financial assistance application, please contact our Business Office at (310)510-0700 X112 from 8:30 a.m. to 4:00 p.m. Monday-Friday.

You may submit your completed application and documents to the hospital front desk 24 hours a day, 7 days a week.

To mail the application and documents, please send to:

Catalina Island Health
P.O. Box 1563
Avalon, CA 90704

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaint.hcai.ca.gov for more information and to file a complaint.

Help Paying Your Bill

There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to www.healthconsumer.org for more information.

Patient Name:
Patient Address:

Patient Number:
Date (s) of Service:

Financial Assistance / Charity Screening Form

The Catalina Island Health's Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs who are low-income, uninsured, or underinsured, ineligible for a government program, or are otherwise unable to pay for medically necessary care based on their individual family financial situation.

To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your timely cooperation will allow us to review your application and quickly determine your eligibility for financial assistance. Please complete the questionnaire below and return it with copies of your pay stubs, bank statements and additional documents.

Patient name:_____

Catalina Island Health Account # _____

Your name(s) and address (including country):

Phone numbers (circle best daytime number)

Home: _____ Your work: _____

Your spouse's work: _____

Date(s) of birth: Yours: Your spouse's/guarantor:

Your employer or business (name and address)/Your spouse's employer or business (name and address):

Age and relationship of people who live with you and are claimed on your tax returns (dependents only):

Patient Name:
Patient Address:

Patient Number:
Date (s) of Service:

Financial Assistance / Charity Screening Form

MONTHLY/ANNUAL INCOME

Please provide two months of photocopies of paystubs and bank statements and listed income.

	Monthly	Annual
Wages (self)	_____	_____
(spouse)	_____	_____
(Other family member)	_____	_____
Other Income	_____	_____
TOTAL INCOME	**$**_____	**$**_____

- I declare the answers I have given are true and correct to the best of my knowledge.
- I agree to tell the provider of services, within 10 days, if there are any changes in my (or my family's) income, property, expenses, or in the persons in the household or of any change of addresses.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the hospital from proceeds from any litigation or settlement resulting from such act.
- I understand that if I do not qualify for uncompensated services, I will be responsible for charges related to services received, and eligible for payment arrangements. I may appeal the charity determination decision in writing with additional documentation.

Signature_____ Date _____

Patient/Guarantor_____ Date _____