**Important Billing Information Summary**
**for Uninsured/Underinsured Patients**

Thank you for choosing Tri-City Health Care District for your hospital services. This handout is designed to help our patients understand our billing process, payment options, and services available.

Financial Assistance (Charity Care) is available to you if you don't have the resources to pay your hospital expenses and don't qualify for any government programs. Any uninsured patient who indicates an inability to pay will be screened for charity care. Additionally, at the discretion of the Hospital, any insured patient who indicates an inability to pay their liability after their insurance has paid will be screened for charity care.

This information applies only to your hospital bill and does not include any bills received from physicians, anesthesiologists, laboratory tests, clinical professionals, ambulance companies, etc. that may bill you separately for their services.

An emergency physician, as defined in Section 127450 of California Health & Safety code Chapter 2.5 of Division 107, who provides emergency medical services in a hospital that provides emergency care, is also required by law to provide discounts to the uninsured patients or patients.

**Medi-Cal & Government Program Eligibility*:*** You may be eligible to receive benefits from a government sponsored health benefit program. Tri-City Health Care District has staff available to assist you with applying for government assistance to pay your hospital bill. This facility also contracts with a company that may assist you further, if needed. Please contact (760) 940-7059 or (760) 940-7064 for assistance.

**Tri-City Health Care District Financial Assistance Program:** Uninsured patients or patients who have an inability to pay their bill may be eligible for charity assistance. The eligibility for charity is based on income and family size. Financial Assistance Assessment Request form is attached. If you have any questions, or if you would like to pay by telephone, please contact the Billing Office at (760) 940-7329.

**Financial Assistance from San Diego County*:*** 2-1-1 San Diego can help you locate financial assistance for energy bill payment, medical expenses, public programs, mortgage consultation and more. You can reach the program by calling 2-1-1 from your home phone, cell phone or by this link http://211sandiego.org/financial-assistance

**How do I apply for Financial Assistance?**
You may obtain an FA Application form from the Patient Access Department or by calling the Billing Office at (760) 940-7329. The Billing Office will mail you a form to complete including instructions on where to mail the completed application and required income documentation. An application is also attached on the last page of this handout. You must provide income documentation, recent tax statement, pay stubs, employer salary history, etc. with your application to process your charity request.



4002 Vista Way | Oceanside, California 92056 | 760.724.8411 | Tricitymed.org

The Billing Office will process your application and may need to contact you as part of the application process and may request additional information. If you need assistance in completing the form please (760) 940-7329.

**How does the notification process work?**

Once the eligibility process is complete you will receive a financial assistance notification letter in the mail. The form will indicate if you are eligible for full or partial Financial Assistance. You may receive a notification that you are ineligible for financial assistance or that more information is needed to make a determination. Your financial assistance application may be pended if you have applied for another health coverage program at the same time until the outcome for that application has been determined.

**Instructions for Completing the Application for Financial Assistance:**

In order to determine if you qualify for charity care or other financial assistance, please complete the attached financial assessment request form. In addition, we request copies of the following documents:

- Current employers pay stubs or other statements of income for all family members.
- Current bank statement(s) for all family members.
- Previous year's tax return.
- Monthly household expenses not included on the application.

Once completed, the application and supporting documents can be submitted to any registration team member, cashier, or patient financial services staff.

# PATIENT FINANCIAL ASSESSMENT REQUEST FORM

Tri-City Medical Center

**Date:**_____

| | | |
|---|---|---|
| **PATIENT NAME: LAST** | **FIRST** | **MIDDLE** |
| **PATIENT ADDRESS:** | | **MEDICAL RECORD #** |
| **CITY, STATE & ZIP** | **PATIENT SOCIAL SECURITY #** | **FAMILY SIZE (REQUIRED)** |
| **MAIDEN NAME OR OTHER:** | | **PHONE #:** ( ) |
| **NEXT OF KIN NAME:** | **PHONE #: ( )** | **WORK PHONE** ( ) |
| **EMERGENCY PHONE** | **PATIENT DOB** | **CELL PHONE:#** ( ) |

| **RESPONSIBLE PARTY** | | **SPOUSE** | |
|---|---|---|---|
| **NAME** | **OCCUPATION** | **NAME** | **OCCUPATION** |
| **EMPLOYER (IF SELF EMPLOYEE DESCRIBE)** | **SOCIAL SECURITY #** | **EMPLOYER (IF SELF EMPLOYEE DESCRIBE)** | **SOCIAL SECURITY #** |
| **ADDRESS** | | **ADDRESS** | |
| **SUPERVISOR NAME** | | **SUPERVISOR NAME** | |
| **PHONE** | **YEARS** | **PHONE** | **YEARS** |
| **INCOME (REQUIRED)** $_____ ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY | | **INCOME (REQUIRED)** $_____ ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY | |

| **ASSETS** | **LIABILITIES** |
|---|---|
| **CASH ON HAND** ..... $_____ | **REAL ESTATE PAYMENTS** ..... $_____ |
| **CHECKING ACCOUNT** ..... $_____ | **INSURANCE PREMIUMS (AUTO/MED/HOME)** ..... $_____ |
| **SAVINGS ACCOUNT** ..... $_____ | **TAXES** ..... $_____ |
| **CREDIT UNION ACCOUNT** ..... $_____ | **UTILITIES** ..... $_____ |
| **PROPERTY OWNED VALUE** ..... $_____ | **AUTO PAYMENTS** ..... $_____ |
| **MOTOR VEHICLES OWNED** ..... $_____ | **FOOD** ..... $_____ |
| **MAKE:** _____ **YEAR** _____ | **HOUSE PAYMENT IF RENTING** ..... $_____ |
| **MAKE:** _____ **YEAR** _____ | **OTHER LIABILITIES: (ATTACH SEPARATE SHEET IF NECESSARY)** |
| **HOME OWNER ESTIMATED VALUE** ..... $_____ | **DESCRIBE** **PAYMENT** **BALANCE** |
| **OTHER SOURCES/ (STOCK BONDS)** ..... $_____ | _____ _____ _____ |
| | _____ _____ _____ |
| **BANK BRANCH(S) & ACCOUNT NUMBERS** | |

**I/WE HEREBY DECLARE THE FOREGOING TO BE TRUE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA.**

_____ _____

**SIGNATURE(S)** **DATE**

## FOR PA USE ONLY

**350% FPL**_____ **APPROVED:** ☐ **YES** ☐ **NO** **BY WHOM:** _____

Rev (3/16)

**IF PARTIAL AMOUNT: $**_____