



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.

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>

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) 940-5912.

**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) 940-5912. 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. 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) 940-5912.

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.



Tri-City Medical Center

FINANCIAL ASSISTANCE APPLICATION FORM

Provided in Accordance with Cal. Health & Safety Code §127425(c)(5)

Application Date:	Date of Service:
Patient Name:	Account Number:
Street Address:	Phone Number:
City, State, ZIP:	Patient Date of Birth:

Please call 760-940-5912 for any questions about filling out this form.

- 1) Was the patient a resident of California at the time of service? Yes No
- 2) Did the patient have medical insurance at the time of service? Yes No
- 3) Was the patient an active Medicaid recipient at the time of service? Yes No

**If you answered yes to questions 2 or 3, please attach a copy of your insurance or Medicaid card to this application.

INCOME:

- All adult family members' income must be disclosed. Income includes gross (before taxes) wages, rental income, unemployment compensation, social security benefits, public assistance, dividends and interest, etc.
- "Family" is defined as follows: (i) for persons 18 years of age and older, family means spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (ii) for persons under 18 years of age, family means parents, caretakers, relatives, and other children under 21 years of age of the parent or caretaker relative. If the patient is a minor, the "family" is defined as the patient, the patient's natural or adoptive parents and the parent's other children (natural or adoptive) who live in the patient's home.

Family Member's Name	Age	Date of Birth	Relationship to Parent	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service

**Please attach additional family member information if applicable.

- Proof of income must be supplied at the time of application (e.g., three months of pay stubs, most recent tax return (IRS Form 1040), etc.).
- If you report \$0 income, please provide a written statement of how you (or the patient) are surviving financially, including who provides food, shelter, transportation, etc. and how long you have been without income.

MONTHLY EXPENSES:		ASSETS	
		This information may be used if your income is above 200% of Federal Poverty Level guidelines to determine whether you may be eligible for discounted care.	
Monthly rent/mortgage	\$	Checking account	\$
Utilities	\$	Savings account	\$
Car payment	\$	Business ownership	\$
Medical expenses	\$	Stocks and bonds	\$
Insurance premiums (life, home, car, medical)	\$	Real estate (excluding primary residence)	\$
Clothing, groceries, household goods	\$		
Other debt/expenses (e.g., child support, loans, other)	\$		

My signature below certifies that everything I have stated on this application is correct and subject to review under audit. I understand that if the information I provide is determined to be false, financial assistance may be denied and I may be responsible to pay for services provided.

Applicant's Signature

Date

Please return completed application to:

TRI-CITY MEDICAL CENTER
ATTENTION PATIENT ACCOUNTING/CSR
4002 VISTA WAY
OCEANSIDE CA 92056