



Charity Care and Discounted Payment Programs

Dameron Hospital (“the Hospital”) recognizes that many of the patients it serves may be unable to access quality health care services without financial assistance. The Charity Care and Discounted Payment Policy was developed to ensure that the Hospital continues to uphold its mission of providing quality health care to the community, while carefully taking into consideration the ability of the patient to pay.

The Hospital’s Charity Care and Discounted Payment Policy, the Financial Assistance Application form, and a plain language summary of the Policy are available on the Hospital’s website at <http://www.dameronhospital.org/> and are available for download and printing. Copies are also available upon request and without charge, both by mail and at all points of registration, including the emergency department, the billing office, the admissions office and other outpatient settings. The Charity Care and Discounted Payment Policy, the Financial Assistance Application form, and a plain language summary of the Policy are also available in Spanish.

Eligible Services

Financial assistance provided to Hospital patients pursuant to the Charity Care and Discounted Payment Programs shall only apply to charges incurred for Emergency Medical Care and other Medically Necessary Services.

Emergency Medical Care and other Medically Necessary Services provided by professionals or physicians, other than the hospital facility itself, are not covered by the Hospital’s financial assistance policies. Professional or physician services include:

- Ambulance Services
- Audiology
- Anesthesiology
- Cardiology
- Dentistry
- Dermatology
- Dialysis
- Emergency Physicians
- Endocrinology
- Gastroenterology
- Gynecology
- Hospitalists
- Internal Medicine
- Magnetic Resonance Imaging (MRI)
- Neonatology
- Nephrology
- Neurology
- Nuclear Medicine
- Obstetrics
- Otolaryngology (ENT)
- Ophthalmology
- Pathology
- Physician Assistants
- Podiatry
- Psychiatric Services
- Radiation Therapy
- Radiology
- Respiratory Care
- Surgeons
- Urology

General Eligibility

The Hospital shall determine eligibility for the Charity Care Program or Discounted Payment Program based upon an individual’s financial need in accordance with the Charity Care Program and Discounted Payment Policy. Patients seeking Charity Care or Discounted Payment must make reasonable efforts to provide the Hospital with documentation of income and health benefits coverage. If a patient fails to provide the information specified in the Charity Care Program and Discounted Payment Policy, the Hospital may consider such failure in making its determination.

Patients that meet certain low- and moderate-income requirements may qualify for discounted payment or charity care. Generally, “Financially Qualified Patients” are those patients (1) who are Self-Pay Patients (i.e., do not have third-party coverage) or Patients with High Medical Costs; and (2) whose family income does not exceed 350 percent of the current federal poverty level.

Before a patient can be eligible for the Charity Care Program or the Discounted Payment Program, all available resources must first be applied, including, but not limited to, private health insurance (including coverage offered through the California Health Benefit Exchange), Medicare, Medi-Cal, the Healthy Families Program, the California Children’s Services Program, or other state- or county-funded programs designed to provide health coverage.



Patients who are eligible for and/or receive financial assistance under the Charity Care Program or the Discounted Payment Program may not receive financial assistance pursuant to the Hospital's Uninsured Patient Discount Policy. Patients who are eligible for and/or receive financial assistance under the Charity Care Program or the Discounted Payment will not be charged more than the "amount generally billed" ("AGB") for such services.

Financial assistance under this Policy shall be provided to eligible patients without regard to race, religion, color, creed, age, gender, sexual orientation, national origin or immigration status.

Application Procedures

Attached you will find a statement of financial conditions that must be filled out in its entirety. To be considered for Charity Care or Discounted Payment under the Policy, the patient must provide the Hospital with the financial and other information requested on the application needed to determine eligibility, which will be considered in accordance with the limitations set forth in the California Health and Safety Code Section 127405(e). This includes completing the required application forms and cooperating fully with the information gathering and assessment processes. If the Hospital determines the patient is eligible for the Charity Care Program, it may require waivers or releases from the patient or the patient's family authorizing the Hospital to obtain verifying information from financial or commercial institutions, or other entities that hold or maintain the monetary assets. If the Hospital determines the patient is eligible for financial assistance under the Discounted Payment Program, documentation of income will be limited to recent pay stubs and income tax returns.

A patient's failure to mail or otherwise deliver to Hospital a complete Financial Assistance Application within 30 days of the final billing statement, which shall be sent at least 90 days from the date of the first post-discharge billing statement, shall result in the Hospital beginning collections actions as described in the Hospital's Collection of Past Due Accounts Policy. Please return this application within 30 days, along with the following documents which support the data you entered on the application:

1. Proof of Identity – Provide one of the following:
 - Copy of state issued driver's license
 - Copy of Social Security card
 - Copy of Photo ID
2. Previous Year's Federal and State Income Taxes, including schedules as applicable. If not available please explain why and attach copy of 2 most recent pay stubs.
3. All Saving and Checking Account(s) Statements
4. Rent Receipts (if applicable)
5. Alimony (if applicable)

Mail completed application and required documentation to: Dameron Hospital Association
 Patient Accounting Department
 525 W. Acacia St.
 Stockton, CA 95203

Please contact the Dameron Hospital Credit and Collections Department at (209) 461-3147 between the hours of 7:00 a.m. to 3:30 pm if you have questions or need assistance in completing the attached Statement of Financial Condition application.

Emergency Physician Services

An emergency physician who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs. Please contact the emergency physicians billing office directly for further information regarding their financial assistance programs.



**STATEMENT OF FINANCIAL CONDITION
SCHEDULE OF CURRENT INCOME AND EXPENDITURES**

Your Name: _____ Spouse Name: _____
 Your SS# _____ Spouse SS#: _____
 Address: _____
 City/State/Zip: _____ Phone: _____

A. FAMILY STATUS

1. List all dependents that you support (other than your spouse)

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. EMPLOYMENT AND OCCUPATION

- You are employed by: _____ Position _____
 If self employed, give name of business _____
- Your spouse is employed by: _____ Position _____
 If self employed, give name of business _____

C. CURRENT INCOME

	<u>You</u>	<u>Spouse</u>
1. Gross pay (wages, salary, commissions, tips)	\$ _____	_____
2. Income from operating a business	\$ _____	_____
3. Other income:		
a. Interest and dividends	\$ _____	_____
b. From real estate or personal property	\$ _____	_____
c. Social Security	\$ _____	_____
d. Pension or other retirement income	\$ _____	_____
e. Other (specify) _____	\$ _____	_____
_____	\$ _____	_____
4. Alimony, maintenance or support payments	\$ _____	_____
TOTAL MONTHLY INCOME (total all above)	\$ _____	_____

(PLEASE TURN OVER AND COMPLETE OTHER SIDE)



D. SCHEDULE OF CURRENT EXPENDITURES

1. Home expenses:

- a. Rent or house payment and maintenance cost \$ _____
- b. Household supplies \$ _____
- c. Real estate taxes \$ _____
- d. Utilities
 - Electric and gas \$ _____
 - Water \$ _____
 - Telephone \$ _____
 - Other (specify) _____ \$ _____
- Total Utilities \$ _____

2. Other Expenses:

- a. Spousal or child support \$ _____
- b. Insurance (only if not deducted from wages)
 - Health \$ _____
 - Auto \$ _____
 - Homeowners or renters \$ _____
 - Other (specify) _____ \$ _____
- Total Insurance Expenses \$ _____
- c. Installment Expenses:
 - Auto \$ _____
 - Other (specify) _____ \$ _____
 - Other (specify) _____ \$ _____
- Total Installment Expenses \$ _____
- d. Transportation (including gas & repairs) \$ _____
- e. Education or child care \$ _____
- f. Food \$ _____
- g. Clothing (including laundry or cleaning) \$ _____
- h. Medical, dental, and medicines \$ _____
- i. Other (specify) _____ \$ _____
- Other (specify) _____ \$ _____

TOTAL CURRENT MONTHLY EXPENSES (Total all above) \$ _____

By my signature, I declare under the penalty of perjury that the above schedule of income and expenditures is a true reflection of my monthly income and expenses. I agree to allow Dameron Hospital Association to verify employment status and credit history for the purpose of determining my qualification for financial assistance, as permitted by law.

Date

(Signature of Patient or Guarantor)