Kindred Hospitals

Admission Notice &
Charity Care/Financial Assistance Application Form

California requires all hospitals to provide free or reduced-price care to people and families who meet certain income requirements. You or your family member may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance.

Helpful Terms:

- "Charity Care" refers to the scenario where a patient or guarantor has no financial responsibility.
- "Financial Assistance" refers to the scenario where a patient or guarantor has some financial responsibility but at a discounted rate (*i.e.*, a discount payment).

Charity Care and Financial Assistance are secondary to all other financial resources available to the patient, including the following (collectively, "Third-Party Coverage"):

- Group or individual Medical Plans
- Workers' Compensation
- Medicare/Medi-Cal
- Other State, Federal, or Military programs

In those situations where payment sources are not available, for medically necessary hospital care received on or after Jan 1, 2022, Kindred Hospital will consider patients for Financial Assistance and Charity Care when Third-Party Coverage, if any, has been exhausted, based on the following criteria:

Income as a Percentage of Federal Poverty Level	Percentage Discount	Category
Less than or equal to 200 percent	One Hundred Percent (100%)	Charity Care
201-300 percent	Seventy five percent (75%)	Financial Assistance
301-400 percent	Fifty percent (50%)	Financial Assistance

For patients who are eligible for Financial Assistance, in no event will such patient's or guarantor's responsibility exceed the amount Kindred Hospital would expect in good faith to receive from Medicare or Medi-Cal, whichever is greater, for providing such services. Such patients are also entitled to a reasonable payment plan to allow payment of the discounted price over time.

How to Apply

Any patient may apply to receive free or reduced-price care. A patient seeking Charity Care or Financial Assistance must provide supporting documentation specified in the application unless indicated otherwise. The application form is included in the admission packet provided at the beginning of your stay, from our website www.kindredhospitals.com, or upon request at any Kindred Hospital.

For your application to be processed, you must:

- Provide information about your family (family includes people related by birth, marriage, or adoption who live together)
- Provide information about your family's gross monthly income (income before taxes and deductions)
- Provide documentation for family income
- Attach additional information if needed.
- Sign and date the form.
- You do not have to provide a Social Security number to apply for financial assistance. If you do not have a Social Security number, please mark "Not Applicable" or "NA."
- Mail or fax completed application with all documentation to:

  Kindred Hospital San Francisco Bay Area
  2800 Benedict Drive
  San Leandro, CA 94580
  Fax: (510) 357-1284
- To submit the application in person, please contact the on-site Kindred Patient Relations Representative.
- We will notify you of the final determination of eligibility and appeal rights, if applicable, within fourteen calendar days of receiving a complete financial assistance application, including documentation of income.

For additional questions or further assistance completing the application contact the on-site Kindred Hospital Patient Relations Representative at (510) 357-8300. You may obtain help for any reason, including disability or language assistance.

You may obtain a copy of Kindred Hospital's Charity Care and Financial Assistance Policy by contacting the on-site Kindred Hospital Patient Relations Representative, or by going to the following URL: https://www.kindredhospitals.com/docs/default-source/default-document-library/locations/transitional-care-hospitals/patient-policies/ca-financial-assistance-policy--kindred-hospitals_nl.pdf.

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 HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

More Help

- **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 healthconsumer.org for more information.
- Kindred Hospitals will provide or assist patients and loved ones in obtaining interpretation or translation services as necessary and address the need of those with vision, speech, hearing, and cognitive impairments.

Covered California

You may qualify for a discount on a health plan through Covered California, a free service that connects Californians with brand-name health insurance under the Patient Protection and Affordable Care Act. Visit www.CoveredCA.com for more information.

Shoppable Services

You can find a list of Kindred Hospital's "shoppable services" at the following web page: https://www.kindredhospitals.com/locations/ltac/kindred-hospital-san-francisco-bay-area/patient-experience/what-to-expect

The Centers for Medicare & Medicaid Services defines a "shoppable service" as a service that can be scheduled by a healthcare consumer in advance.

ATTENTION: If you need help in your language, please call (510) 357-8300 or visit the Kindred Hospital San Francisco Bay Area Patient Relations Representative to obtain more information. The office is open 8 a.m. to 5 p.m. Monday through Friday and located at 2800 Benedict Drive, San Leandro, CA 94580.

Aids and services for people with disabilities, like documents in braille, large print, audio and other accessible electronic formats are also available. These services are free.

Kindred Hospital San Francisco Bay Area

Charity Care/Financial Assistance Application Form – confidential

Please fill out all the information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION
Select all that apply: Are you applying for Charity Care (*i.e.*, free care)? □ **Yes** □ **No** Are you applying for Financial Assistance (*i.e.*, reduced-price care)? □ **Yes** □ **No**
Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*
Has the patient applied for Medi-Cal? □ **Yes** □ **No**
Does the patient receive state public services such as EBT-SNAP, or WIC? □ **Yes** □ **No**
Is the patient currently homeless? □ **Yes** □ **No**
Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No**

PLEASE NOTE
• For documentation of income, we only request recent paystubs or income tax returns. We accept, but do not require, other forms of documentation of income. • Patients applying only for Financial Assistance may receive less financial assistance than what may be available to them under the Charity Care program. • We cannot guarantee that you will qualify for financial assistance, even if you apply. • Once you send in your application, we may check all the information and may ask for additional information or proof of income. • Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION			
Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify _____)	Birth Date		Patient Social Security Number (optional*) **Optional, but needed for more generous assistance above state law requirements*
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*) **Optional, but needed for more generous assistance above state law requirements*
Mailing Address _____ _ _____ _ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____

Employment status of person responsible for paying bill
□ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed:_____)
□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:
- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain_____)*

INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.

Proof of income means:

- Current pay stubs (within *3 months*); or
- Last year's income tax return, including schedules if applicable.

You may, <u>but are not required to</u>, provide additional proof of income beyond current pay stubs and last year's income tax return.

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (*child support, loans, medications, other*)

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that ***Kindred Hospital*** may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of Charity Care or Financial Assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date