Staple

Summary Of Financial Assistance Programs

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or underinsured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

Free Care

- If you are uninsured or underinsured with a family income of up to 200% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care

- If you are uninsured or underinsured with an annual family income between 200-500% of the Federal Poverty level, you will be charged the Amount Generally Billed (AGB), which is an amount set under federal law that reflects the amounts that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services that you received.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan.

You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

Traducción disponible: You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.

Chandler Regional Medical Center 1955 W. Frye Road, Chandler, AZ 85224 | **Financial Counseling** 480-728-3564
Patient Financial Services 855-892-2400 | www.dignityhealth.org/chandlerregional/paymenthelp

Mercy Gilbert Medical Center 3555 S. Val Vista Drive, Gilbert, AZ 85297 | **Financial Counseling** 480-728-7281
Patient Financial Services 855-892-2400 | www.dignityhealth.org/mercygilbert/paymenthelp

St. Joseph's Hospital & Medical Center 350 W Thomas Road, Phoenix, AZ 85013 | **Financial Counseling** 602-406-4923
Patient Financial Services 877-877-8345 | www.dignityhealth.org/stjosephs/paymenthelp

St. Joseph's Westgate Medical Center 7300 N 99th Avenue, Glendale, AZ | **Financial Counseling** 866-556-8221
Patient Financial Services 877-877-8345 | www.dignityhealth.org/stjosephs/paymenthelp

Dignity Health®

O:A:S:I:S Hospital

Financial Assistance Application

Patient Account Number(s)

List hospital(s) you were treated

Patient Last Name | Patient First Name | Patient Social Security # | Patient Date of Birth

Guarantor Last Name (If Different) | First Name | Guarantor Social Security # | Date of Birth

Guarantor Home Address | Home Telephone Number

City | State | Zip Code

Guarantor's Employer Name | Guarantor Job Function/Department

Guarantor's Employer Address | Guarantor's Employer Telephone

City | State | Zip Code

Spouse's Employer Name | Spouse's Job Function/Department

Spouse's Employer Address | Spouse's Employer Telephone

City | State | Zip Code

People in household (including applicant)

Name	Relationship to Patient	Date of Birth	Employer	Annual Income
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

Oasis Hospital Health Financial Assistance Application (Continued)

In order to determine who truly qualifies for financial assistance, we must first require submission of the information listed below to demonstrate financial hardship. Please complete the application and return it with all the following items listed below. If you are unable to supply one of the documents or there are additional factors that may influence the evaluation, please submit a written statement explaining your situation.

Documentation Required:

1. Proof of Identity - **One** of the following:
   - Copy of Social Security Card
   - Copy of state issued driver's license
   - Copy of other photo ID

2. Verification of Current Address - **One** of the following:
   - Rent receipt
   - Utility Bill

3. Denial of eligibility from Medi-Cal or Medicaid program from state of residence.

4. Proof of income for all family members* in the 12 months prior to the date on which Oasis Hospital services were provided. This could include the most current Income Tax Return(s) or pay stubs for the same time period. If self-employed, include Schedule C with your Tax Return. If these are unavailable, please write an explanation on a separate piece of paper, stating your financial situation over the last three months, and submit it with this application.

*A Patient's Family includes:

a) For persons 18 years of age and older, a spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.
b) For persons under 18 years of age, a parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

Once we have completed our initial review of the documents provided, the following may be required to determine qualification:

Proof of Monetary Assets - **All** of the following:

- Checking account statements-last 3 months
- Savings account statements-last 3 months
- Stocks, Bonds, & CD's

By signing below you agree to be considered for Payment Assistance. Additionally, you certify that all the statements made on this application are true and complete to the best of your knowledge. Should it be determined that the information you provided is incomplete or false, any discount on your bill may be reversed and payment in full may be expected from you. By signing below, you authorize Oasis Health to check references and credit history in order to evaluate this application for financial assistance consideration.

If you receive payment from an insurance company, workers compensation plan, or any other third party, you agree to inform the hospital of any such payment. The hospital retains its right to collect the original, full billed charges should a third party provide you with payment for the hospital's services.

_____ _____

Signature of person responsible for bill (Guarantor) Date

Mail completed application to:

Oasis Hospital
750 N 40th Street
Phoenix, AZ 85008
602-797-7775

Revised September 9, 2016