Financial Assistance Program Notification & Application

We understand you currently do not have any health insurance. Please inform us immediately if you do have health insurance coverage, Medicare, Medi-Cal, or other coverage. Ridgecrest Regional Hospital ("RRH") participates in the Medi-Cal (Medicaid) hospital presumptive eligibility program, which means that you may qualify for immediate coverage for medically necessary services under Medi-Cal while awaiting permanent Medi-Cal (Medicaid) coverage. You may also be eligible for health insurance under Covered California or through the California Children's Services program. Our Admissions staff can assist you with these applications. Also, RRH has a Patient Financial Assistance program that may be of assistance to you in paying your bill. Enclosed you will find a Financial Assistance Application for you to complete. If you are interested in learning about our charges, you can visit our website for a list of "Shoppable Services" (as defined by law) at https://www.rrh.org/patients-visitors/billing/ and clicking on the price estimator link.

Please fill out the Financial Assistance Application form completely and return it with your proof of income, *for everyone in your household*. **For proof of income you will need to provide at least one of the following**:

- Two recent pay stubs
- A copy of your most current W-2
- Or a recent bank statement (if you have direct deposit)

If you have no income you will need to provide a statement as to how you financially meet your daily needs. If someone is financially assisting you with your daily needs, please have them write a statement stating that they are providing this assistance and how they are doing so.

Please note, you must return the Financial Assistance Application form with appropriate proof of income in order to be considered for this program. Acceptance into this program is decided based on the Federal Poverty Guidelines. We have provided you with a self-addressed stamped envelope in which to return the Financial Assistance Application form and all necessary documentation. If you have applied for another health coverage program, you may still apply for this RRH financial assistance program, and neither application shall preclude eligibility for the other program. However, please advise as to which program(s) you have applied.

There are other organizations that can also assist you in understanding the billing and payment process, including the free Health Consumer Alliance (https://healthconsumer.org; (888) 804-3536). Also, if your application for financial assistance from RRH is denied, you can contact the undersigned or the hospital's Revenue Cycle Administrator.

There is a Hospital Bill Complaint Program which is a state program that 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 HospitalBillComplaint.hcai.ca.gov for more information and to file a complaint.

Should you have any questions please feel free to contact me at the number listed below. I'm in the office from 7:30 to 4:00 Monday thru Friday.

Sincerely,

Patricia Townsley
Personal Pay Patient Representative
Ridgecrest Regional Hospital
901 Heritage Blvd
Ridgecrest, CA 93555
760-499-3010

RIDGECREST REGIONAL HOSPITAL
Financial Assistance Application
1081 N. China Lake Blvd, Ridgecrest, Ca 93555

Account #_____
Date _____

All information must be complete for consideration for financial assistance

Patient Information

Name:_____

Address:_____

City/St/Zip:_____

Employer:_____

Employer Phone: _____

Monthly Net Income: _____

Parent/Spouse/Guarantor Information

Name:_____

Address:_____

City/St/Zip:_____

Employer:_____

Employer Phone: _____

Monthly Net Income: _____

Number of Dependents_____ Names _____ _____ _____ _____

List all other income: $_____ Source_____ $_____Source _____

If unemployed, what is your source of income?_____
(This must be answered if source of income is zero)

You must provide a current pay stub or income tax form.

I declare that the above statements are true and correct to the best of my knowledge. I understand that withholding of information or the giving of false information will make the patient and/or responsible party liable for all charges for services.

Signature:_____ Date:_____

All lines must be filled out. If not applicable, please indicate.

Amount of discount is determined based on income level and Federal Poverty Guidelines. Please refer to the Financial Assistance Program policy available on our website for a complete listing of services covered. Not all Physician professional fees are covered under the Financial Assistance Policy.

Questions: Call 760-499-3010