Grancell Village of the LA Jewish Home for the Aging
Joyce Eisenberg Keefer Medical Center - Auerbach Geriatric Psychiatric Unit (AGPU)
FINANCIAL ASSISTANCE POLICY

Exhibit B (Continued)
APPLICATION FOR FINANCIAL ASSISTANCE

The following is a true statement of all property, securities and investments, cash, bank accounts, insurance policies and assets or sources of income of any and every kind of nature, either in my possession or held by others for my use or benefit, or in which I may have present or future interests:

1. MONTHLY INCOME **AMOUNT PER MONTH**

From Social Security Benefits…Direct Deposits to bank?_____
$_____

From Supplemental Social Security (S.S.I.)…Direct Deposit to bank?_____ _____

From Other Government Agencies (Federal, State or City)…….. _____

Civil Service #_____R.R. Retirement #_____ _____From Veteran's Pensions…….. _____From

Company Pensions…Name of Company_____ _____

From Union Pensions…Name of Union_____ From _____

Other Pensions…Name_____From _____

Foreign Governments, including Pensions, Restitutions and Indemnification Payments

Give Details_____ _____

From Interest on Bank Accounts…….. _____ From

Dividends on Securities…….. _____ From

Interest on Securities (Treasury Notes, Corporate Bonds, etc.) …….. _____ From

Insurance Payments or Annuities…Name of Company_____ _____

From Real Estate (Rents, Interests, etc.)…….. _____

From Bequests, Legacies, or Trusts…Name of Estate or Trust_____ _____

From Alimony…….. _____

From IRA, Keoghs, Tax Sheltered Annuities_____From _____

Children, Names_____From _____

Others, (Relatives and/or Friends, etc.)_____ _____

Total Monthly Income…….. _____

2. MONTHLY LIVING EXPENSES

My monthly rent or mortgage payment is…….. _____

Cost of nursing care per month (if applicable)…….. _____

3. ASSETS

Present Bank Accounts (saving and checking)

1. Name of Bank_____ Address_____ Zip_____ Account No._____ Type of Account_____ Balance Date_____
2. Name of Bank_____Address_____Zip_____ Account No._____Type of Account_____ Balance_____Date_____

(*Use supplemental sheet if space is not sufficient and check here* □)

Exhibit B (Continued)
APPLICATION FOR FINANCIAL ASSISTANCE

List your Real Estate Property: (List residence first)

1. Location_____ Description of Property_____ Current market value_____ Amount of Mortgages against Property_____ Does anyone share the residence with you? □ Yes □ No
   If yes, what is their relationship with you?_____
   How long have they shared the residence with you?_____
2. Location_____ Description of Property_____ Current market value_____ Amount of Mortgages against Property_____

(*Use supplemental sheet if space is not sufficient and check here* □)

List your Securities and Investments (stocks, bonds and notes) as follows: Number of share or dollar amount

_____ _____
_____ _____

Name of Stockbroker_____ Account #_____
Address_____ Telephone # (____) _____

List Retirement Accounts Value

_____ _____
_____ _____

Trust

Do you have a Trust? □ Yes □ No Is Trust Revocable? □ Yes □ No
If yes, name of trustee_____ Address_____
Telephone (____) _____ Total value of Trust_____
Total Monthly Income from Trust_____ Beneficiary_____

Does anyone owe you money? □ Yes □ No Amount_____
If yes, please explain_____
List all Insurance Policies which have a cash value.
Company_____ Policy #_____
Amount_____

List any other assets or financial information not described_____
_____

Do you have a Safety Deposit Box? □ Yes □ No Location_____ Number_____ Do you have a Will? □ Yes □ No In whose possession is it?_____ What is your attorney's name?_____
Address_____ Zip_____ Telephone # (____) _____

Have you made the following legal arrangements?

1. Durable Power of Attorney – Health Care □ Yes □ No
2. Durable Power of Attorney – General □ Yes □ No

3. Conservatorship of person □ Yes □ No

Exhibit B (Continued)
APPLICATION FOR FINANCIAL ASSISTANCE

Exhibit B (Continued)
APPLICATION FOR FINANCIAL ASSISTANCE

4. Conservatorship of estate □ Yes □ No
5. Other_____

For each item marked "yes", please complete the following:

1. _____ _____
Legal arrangement Name of agent

_____ _____ ( )
Relationship to applicant Address Phone

(*Use supplemental sheet if space is not sufficient and check here* □)

Have you made any prepaid funeral and/or burial arrangements? □ Yes □ No
Do you own a burial plot, vault or crypt? □ Yes □ No If yes, give details_____
_____
_

Name of Mortuary
(Mandatory)_____
Address_____Zip_____Telephone ( )_____

Have you closed bank accounts, sold, transferred, assigned, made any gifts, or otherwise disposed of any money, securities, insurance policies, real or personal property or other assets within the past five years? □ Yes □ No
If yes, specify date closed or transferred, market value of assets, and to whom transferred.
_____
_____
_____

I hereby declare that each and all of the foregoing statements are true, correct and complete. I also understand that this Part B is an integral part of my application to the Home and that my application may be rejected for any incorrect and incomplete information given herein.

_____ _____
Signature of Applicant or Designee Date

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FINANCIAL ASSISTANCE POLICY

Exhibit C
FINANCIAL ASSISTANCE CALCULATION WORKSHEET

Patient Name:_____ Patient Account #:_____

Special Considerations/Circumstances: _____

_____

_____

_____

	Yes	No
Does Patient have Health Insurance?	☐	☐
Is Patient Eligible for Medicare?	☐	☐
Is Patient Eligible for Medi-Cal?	☐	☐
Is Patient Eligible for Other Government Programs (i.e. Crime Victims etc.)?	☐	☐

If the patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a hospital charity care or discount payment program, neither application shall preclude eligibility for the other program.

Does Patient have other insurance (i.e. auto medpay)?	☐	☐
Was Patient insured by a third party?	☐	☐
Is Patient Self-Pay?	☐	☐

Financial Assistance Calculation:

Total Combined Current Monthly Family Income (From Application for Financial Assistance) $_____

Family Size (From Application for Financial Assistance) _____

Qualification for Financial Assistance Met Yes No

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FINANCIAL ASSISTANCE POLICY

Exhibit D
NOTIFICATION FORM
ELIGIBILITY DETERMINATION FOR FINANCIAL ASSISTANCE

AGPU has conducted an eligibility determination for financial assistance for:

_____	_____	_____
PATIENTS NAME	ACCOUNT NUMBER	DATE(S) OF SERVICE

The request for financial assistance was made by the patient or on behalf of the patient on_____
This determination was completed on_____.

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

Your request for financial assistance has been approved for services rendered on_____.
After applying the financial assistance reduction, the amount owed is $_____.

Your request for financial assistance is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____
_____
_____

Your request for financial assistance has been denied because:

REASON:

_____
_____
_____

Granting of financial assistance is conditioned on the completeness and accuracy of the information provided to AGPU. In the event AGPU discovers you were injured by another person, you have additional income, you have additional insurance or provides incomplete or inaccurate information regarding your ability to pay for the services provided, the hospital may revoke its determination to grant Financial Assistance and hold you and/or third parties responsible for the hospital's charges.

If an application has been submitted for another health coverage program at the same time that you submit an application for Financial Assistance, neither application shall preclude eligibility for the other program.

If you have any questions on this determination, please contact:

_____

Program Director, AGPU
818-758-5045

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FINANCIAL ASSISTANCE POLICY

Exhibit E

Important Billing Information for Patients
Financial Assistance / Plain Language
Summary

This handout is designed to help our patients understand the Financial Assistance that is available to eligible patients, the application process for Financial Assistance, and your payment options. Your hospital bill will not include any bill for services you may receive during your hospital stay from physicians or any other providers that may bill you separately for their services. If you wish to seek assistance with paying your bills from these other providers, you will need to contact the providers directly.

Payment Options: AGPU has many options to assist you with payment of your hospital bill.

Medi-Cal & Government Program Eligibility: You may be eligible for a government-sponsored health benefit program. Please contact the AGPU Program Director (818) 758-5045 if you would like additional information about government programs, or need assistance with applying for such programs.

Covered California: You may be eligible for health care coverage under Covered California, which is California's health benefit exchange under the Affordable Care Act. Contact the AGPU Program Director (818) 758-5045 for more detail and assistance to see if you quality for health care coverage through Covered California.

Payment Plans: Patient account balances are due upon receipt. Patients may be eligible to make payment arrangements for their hospital bill. The payment plan is negotiated between the Hospital and the patient., and a Financial Agreement must be signed before AGPU can accept payment arrangements that allow patients to pay their hospital bills over time.

Summary of Financial Assistance (Charity Care): The AGPU is committed to providing financial assistance to Patients who have no third-party source of payment, such as an insurance company or government program, for any portion of their medical expenses **and** have a family income at or below 400% of the federal poverty level. The following is a summary of the application process for patients who wish to seek Financial Assistance.

You may apply for Financial Assistance using the application form that is available from the AGPU Program Director by calling 818-758-5045 or the Director of Social Services at 818-758-5038, or on the AGPU or Hospital website (www.lajh.org). During the application process you will be asked to provide information regarding the number of people in your family, your monthly income, and other information that will assist the hospital with determining your eligibility for Financial Assistance. You may be asked to provide a pay stub or tax records to assist AGPU with verifying your income.

After you submit the application, the hospital will review the information and notify you in writing regarding your eligibility. If you have any questions during the application process, you may contact the AGPU Program Director at (818) 758-5045.

If you disagree with the hospital's decision, you may submit a dispute to the AGPU Program Director

Exhibit E (continued)

Important Billing Information for Patients
Financial Assistance / Plain Language Summary

Copies of this Financial Assistance Policy, the Plain Language Summary and Application, as well as government program applications are available in English and Spanish in person at the AGPU Program Director's office as well as at www.lajh.org and available by mail. We can also send you a copy of the Financial Assistance Policy free of charge if you contact our AGPU Program Director at 818-758-5045 or the Director of Social Services at 818-758-5038

In accordance with Internal Revenue Code Section 1.501(r)-5, AGPU adopts the prospective Medicare method for amounts generally billed; however, patients who are eligible for Financial Assistance are not financially responsible for more than the amounts generally billed.

Pending applications: If an application has been submitted for another health coverage program at the same time that you submit an application for Financial Assistance, neither application shall preclude eligibility for the other program.

Notice of Availability of Financial Estimates: You may request a written estimate of your financial responsibility for Hospital Services. Requests for estimates must be made during business hours. The estimate will provide you with an estimate of the amount the hospital will require the patient to pay for health care services, procedures, and supplies that are reasonably expected to be provided by the hospital. Estimates are based on the average length of stay and services provided for the patient's diagnosis. They are not promises to provide services at fixed costs. A patient's financial responsibility may be more or less than the estimate based on the services the patient actually receives.

The hospital can provide estimates of the amount of Hospital Services only. There may be additional charges for services that will be provided by physicians during a patient's stay in the hospital, such as bills from personal physicians, and any other medical professionals who are not employees of the hospital. Patients will receive a separate bill for these services.

If you have any questions about written estimates, please contact the AGPU Program Director 818-758-5045 or the Director of Social Services at 818-758-5038.

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Exhibit F

Notice of Rights

Thank you for selecting AGPU for your recent services. Enclosed please find a statement of the charges for your hospital visit. **Payment is due immediately.** You may be entitled to discounts if you meet certain financial qualifications, discussed below.

Please be aware that this is the bill for Hospital Services only. There may be additional charges for services that will be provided by other medical professionals during your stay in the Hospital, such as bills from physicians, and any anesthesiologists, pathologists, radiologists, ambulance services, or other medical professionals who are not employees of the hospital. You may receive a separate bill for their services.

Summary of Your Rights: State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, or making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (328-4357) or online at www.ftc.gov.

Nonprofit credit counseling services, as well as consumer assistance from local legal services offices, may be available in your area. Please contact the AGPU Program Director 818-758-5045 for a referral.

The AGPU may use external collection agencies to collect payments from patients. Collection Agencies are required to comply with the Hospital's policies. Collection Agencies are also required to recognize and adhere to any payments plans agreed upon by the Hospital and the patient.

Financial Assistance: AGPU is committed to providing Financial Assistance to qualified low income patients who have no third-party source of payment, such as an insurance company or government program, for any portion of their medical expenses **and** have a family income at or below 400% of the federal poverty level.

You may apply for Financial Assistance using the application form that is available from the AGPU Program Director or Director of Social Services located within the AGPU, or by calling the Program Director at 818-758-5045 or the Director of Social Services at 818-758-5038, or on the AGPU or Hospital website (www.lajh.org). You may also submit an application by speaking with the AGPU Program Director or Director of Social Services who can assist you with completing the application. During the application process you will be asked to provide information regarding the number of people in your family, your monthly income, and other information that will assist the Hospital with determining your eligibility for Financial Assistance. You may be asked to provide a pay stub or tax records to assist the Hospital with verifying your income.

After you submit the application, the Hospital will review the information and notify you in writing regarding your eligibility. If you have any questions during the application process, you may contact the AGPU Program Director at 818-758-5045.

If you disagree with the hospital's decision, you may submit a dispute to the AGPU Program Director's office.

Exhibit F (continued)

Copies of the Hospital's Financial Assistance Policy, the Plain Language Summary and Application, as well as government program applications are available in multiple languages in person at the AGPU Program Director or Director of Social Services office, as well as at lajh.org and available by mail. We can also send you a copy of the Financial Assistance Policy free of charge if you contact our AGPU Program Director at 818-758-5045.

In accordance with Internal Revenue Code Section 1.501(r)-5, AGPU adopts the prospective Medicare method for amounts generally billed; however, patients who are eligible for Financial Assistance are not financially responsible for more than the amounts generally billed.

Pending applications: If an application has been submitted for another health coverage program at the same time that you submit an application for Financial Assistance, neither application shall preclude eligibility for the other program.

Health Insurance / Government Program Coverage/Financial Assistance: If you have health insurance coverage, Medicare, Medi-Cal, California Children's Services, or any other source of payment for this bill, please contact the AGPU Program Director at 818-758-5045. If appropriate, we will bill those entities for your care.

If you do not have health insurance or coverage through a government program like Medi-Cal or Medicare, you may be eligible for government program assistance. The AGPU Program Director or Director of Social Services can provide you with application forms, and assist you with the application process.

If you have received an award of Financial Assistance from the Hospital that you believe covers the services that are the subject of this bill, please contact the AGPU Program Director at 818-758-5045.

California Health Benefit Exchange: You may be eligible for health care coverage under Covered California. Contact the AGPU Program Director for more detail and assistance to see if you quality for health care coverage through Covered California.

Contact Information: The AGPU Program Director or Director of Social Services are available to answer questions you may have about your hospital bill, or would like to apply for Financial Assistance or government program. The telephone numbers are 818-758-5045 or 818-758-5038 during the hours of 8:00 A.M. to 5:00 P.M., Monday through Friday.