Rady Children's Hospital – San Diego
FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION WORKSHEET

Patient Name: _____
Account Number(s): _____

Special Considerations/Circumstances:
_____
_____
_____

	Yes	No
Does patient have insurance?	❑	❑
Is patient eligible for Medi-Cal?	❑	❑
Is patient eligible for other Government Programs?	❑	❑

If eligibility exists for above programs, patient will not generally be eligible for charity care (unless care was provided when the patient's eligibility status was not yet established).

Is patient self-pay?	❑	❑

Charity/Financial Assistance Calculation

Total Combined Current Monthly Income (from Statement of Financial Condition) $_____

Total Annual Income $_____

Income Verification Code _____
Family Size (from Statement of Financial Condition) _____

Total Medical Expense Liability $_____

Qualification for Charity Care/Financial Assistance

1. Is total annual household income equal to or less than 250% of the Federal Poverty Guidelines?
   (See Financial Assistance Eligibility Guidelines – Schedule A) **Circle one**

   YES Approved for 100% financial assistance; only co-payment on Schedule A is required

   NO Does not qualify for assistance. Continue to step 2.

2. Is total annual household income equal to or less than 450% (between 251% to 450%) of the Federal Poverty Guidelines? (See Financial Assistance Eligibility Guidelines – Schedule A) **Circle one**

   YES Total Annual Income is greater than ___% and less than ___% of the Federal Poverty Guidelines. Patient/guarantor qualifies for partial charity care discount as pursuant to Financial Assistance Eligibility Guidelines

(Schedule A) and, therefore, patient/guarantor is eligible for one of the following levels on the discounted Private Pay Fee Schedule:

- Up to 350 percent of FPL 75% discounted rate
- Up to 450 percent of FPL 50% discounted rate

(Note: All self-pay patients with incomes greater than 450 percent of the FPL will be offered a 25% discount off of charges as part of our prompt pay program. These patients should not require a financial assistance application unless their medical expense liability is unwieldy and should be considered for catastrophic eligibility.)

NO Continue to worksheet to assess possible catastrophic eligibility – Upper Limit Patient Liability Worksheet.

Charity Care/Financial Assistance Discount

Determined discount level _____%
Balance Due from discounted Private Pay Fee Schedule $_____

Worksheet completed by:

_____	_____	_____
Employee name (please print)	Title	Phone

_____	_____
Employee signature	Date

Approved by:_____ Date:_____
Approved by:_____ Date:_____
Approved by:_____ Date:_____
Approved by:_____ Date:_____
Approved by:_____ Date:_____

Notes:
Approval Matrix

Up to $5,000	Financial Counselor or Biller/Follow Up Collector
Up to $10,000	PFS Supervisor or Inpatient Admissions/Financial Counseling Supervisor
Up to $25,000	Patient Access Director or PFS Manager
Up to $50,000	PFS Director or Revenue Cycle Director
Up to $100,000	CFO or COO
$100,001 and above	CFO and COO

Income Verification Codes

1	IRS Form W-2, Wage and Earnings Statement	6	Bank statements
2	Recent pay stubs/paycheck remittance	7	Written attestation of guarantor
3	Tax returns	8	Verbal attestation of guarantor
4	Social Security, Work Comp or Unemployment Comp letter	9	Government Program
5	Telephone verification by employer	10	Other