For Catastrophic Eligibility only:

Rady Children's Hospital – San Diego
Upper Limit Patient Liability Worksheet

PATIENT NAME _____
ACCOUNT NO. _____
GUARANTOR NAME _____
GUARANTOR NAME _____
ADDRESS _____
_____
PHONE _____

Is the patient eligible for charity care?

_____ Yes (*Refer to "Financial Assistance, Discount Payment, and Billing and Collection" policy and Financial Assistance Eligibility worksheet for further instructions.*)
_____ No (*Complete form to determine applicable ceiling.*)

A. Total patient liability: _____

B. Total annual household income: _____

C. Upper limit charge for ceiling for patient (B x _____%)*: _____

D. **Amount to be billed:** _____

(*If* A < C, *billed amount is* A. *If* A > C, *billed amount is* C.)

Remaining Balance Write – Off:

_____ Charity Care/Financial Assistance
_____ Bad Debt
_____ Other (Specify:_____)

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:_____

***Upper limit charge:** 20% of annual household income for guarantors less than 350% of FPL; or
30% of annual household income for guarantors greater than 350% of FPL.