Charity Care Assistance Program

Patients must be honest and forthcoming when providing all information requested by LVMC as part of the financial assistance screening process. Patients are required to provide accurate and truthful eligibility documentation reasonably necessary for financial assistance coverage through any government coverage program or the LVMC Financial Assistance Program. Honesty implies and requires full and complete disclosure of required information and/or documentation.

All uninsured patients and those who request financial assistance will be required to complete a Financial Assistance Application. Prior to leaving LVMC, patients should verify what additional information or documentation must be submitted by the patient to LVMC. The patient shares responsibility for understanding and comply with the document filing deadlines of LVMC or other financial assistance programs.

Patients should expect and are required to pay any or all amounts due at the time of service. Said amounts due may include, but are not limited to:

- Co-Payments
- Deductibles
- Deposits
- Medi-Cal/Medicaid Share of Cost Amounts

The patient also shares a responsibility to assure that arrangements for settling the patient account have been completed. It is essential that each patient or their family representative cooperates and communicates with LVMC personnel during and after services are rendered.

The information you are presenting is an application and other financial disclosure information and not a guarantee of approval. The information presented will be reviewed and analyzed timely against the Federal Poverty Criteria.

Please allow four or six weeks for review of your charity care assistance application and supporting documents before a ruling will be made on your application. If you have any questions please call, (805)875-8908.

Charity Financial Assistance Application

Patient Name: _____ Patient Visit Number: _____

Patient Date of Birth: _____ Patient Social Security Number: _____

Guarantor Name (If Different): _____ Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Family Size (As reported on tax return): _____ Combined Monthly Income: _____

Family Members:

Name: _____ Age:_____

Name: _____ Age:_____

Name: _____ Age:_____

Name: _____ Age:_____

	Yes	No
Does Patient have Insurance?	☐	☐
Is Patient Eligible for Medicare?	☐	☐
Is Patient Eligible for Medi-Cal?	☐	☐
Is Patient Eligible for other Government Programs?	☐	☐
Is Patient Self-Pay?	☐	☐

FAMILY INCOME SOURCES

Income	Patient Amount	Spouse Amount
Wage & Salary	_____	_____
Self-Employment	_____	_____
Interest & Dividends	_____	_____
Real Estate Rentals & Leases	_____	_____
Social Security	_____	_____
Alimony	_____	_____
Child Support	_____	_____
Unemployment	_____	_____
Disability	_____	_____
Public Assistance	_____	_____
All Other Income	_____	_____

The following documents are required as proof of income:

1. Copy of recent Federal income tax return.
2. Copy of 2 recent pay stubs or other income (i.e., disability, unemployment, SS benefits)

If you are not receiving consistent income, write a brief paragraph on a separate paper stating your financial situation over the last three months. Explain how or from what source you are receiving monies to pay for your basic living expenses such as food and housing.

The above information is accurate and correct to the best of my ability, and I hereby grant Lompoc Valley Medical Center and/or their representative permission to verify this information.

I also understand that I am to submit the appropriate documents as required by LVMC which will reveal family income, deductions and net wages, for a designated time period.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____