DISCOUNT PROGRAM APPLICATION

The Ventura County Health Care Agency (VCHCA) is committed to providing the highest quality healthcare and emergency services to members of our diverse community. Our mission is to provide excellent comprehensive, cost-effective, compassionate healthcare throughout Ventura County.

At VCHCA we strive to make health care available to everyone in our community, regardless of their ability to pay. Our programs include a Discount Program (DP) for patients at Ventura County Medical Center (VCMC) and Santa Paula Hospital, Eastman Physical Therapy, and clinics licensed under VCMC (Anacapa, Academic Family Medicine, medical specialties, and pediatric and adult hematology oncology clinics). The DP has six pay discount levels based on individual or family income. You can request financial assistance if your household income is at or below 400% of the Federal Poverty Level (FPL). Payment plans are also available for families with incomes above 400% of FPL. (*Please note that for patients in our Federally Qualified Health Centers, there is a separate application for our Sliding Fee Discount Program).*

PROGRAM AVAILABILITY LOCATIONS MARKED WITH ●

Program Number	% of the Federal Poverty Level	Discount Program at non-FQHC Clinics	Discount Program at VCMC & SPH
1	0% to 100%	●	●
2	100.01% to 138%	●	●
3	138.01% to 150%	●	●
4	150.01% to 200%	●	●
5	200.01% to 400%	●	●
6	greater than 400%	●	●

Who is Eligible for Discount Program:

- Individuals not eligible for insurance coverage.
- Have insurance coverage (with high out of pocket cost).
- Meet applicable income guidelines.
- Immigration status not required.

To Apply for Discount Program Please Submit Documents Below:

- Proof of income such as a paycheck stub or tax return.
- Knowledge of household income and living expenses (if applying for payment plan).
- Current medical bill information (if available).
- Identification (Driver's license, identification card, or passport).

If you need assistance with our Discount Program policy requirements and/or the application, our staff will be happy to assist you. We provide Bilingual and Interpretation Services.

Our commitment to value the diversity of all persons and to be respectful and inclusive of everyone is facilitated by engaging and educating our community, to improve the overall health of everyone in our County. We at Ventura County Health Care Agency look forward in serving you.

Discount Program Application

Applicant/Patient Name: _____ _____ Date: _____ Account (if available) _____
First *Last*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Date of Birth: _____ Social Security or Individual Tax ID: _____
Month/Day/Year

Patient Employer: _____

Guarantor/
Person Responsible for Payment: _____
First *Last*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____

Family Members

First and Last Name	Relationship

Income Information

Forms of Income:	Monthly Total for the Last 12 Months
Wages Total	$
If applicable	$
If applicable	$
	$

Check Proof of Income Attached: Pay Check Stub ☐ Tax Return ☐

**** Complete the Household Expenses section if household income is below 400% and a payment plan is needed for hospital services**

Household Expenses (if applying for payment plan)

Essential Living Expenses	Monthly Totals/Estimates
Rent or Mortgage (including maintenance expenses)	$
Food and Household Supplies	$
Utilities (Water, Gas, Electricity, Trash) and Telephone (cellular and land line)	$
Clothing	$
Medical and Dental Payments	$
Insurance	$
School and Child Care	$
Child and Spousal Support	$
Transportation and Automobile Expenses (Including insurance, fuel, and repairs)	$
Installment Payments (not included above)	$
Laundry and Cleaning Expenses	$
Other Extraordinary Expenses or other Expenses Not Listed Above	$

Disclaimer and Signature

I the applicant/patient consent/agree/understand that my physician may be informed of this application for uncompensated care.

I the applicant/patient understand that I may be asked to prove my statements on this application and that my eligibility is subject to verification by VHCA by contacting my employer, bank and credit card companies for verification, and on-line property searches.

By submitting a Discount Program Application and as provided by federal law, I the applicant/patient, request that VCHCA determine my eligibility for uncompensated services, and understand if the information I provided is determined to be false, VCHCA will deny program eligibility and deny providing services as uncompensated services, and I the applicant/patient will be liable for charges for services provided.

I affirm that the statements made herein are true and correct to the best of my knowledge.

Applicant's Signature: _____ Date: _____

OFFICE USE ONLY SECTION

_____ _____
HCA Date

_____ _____
Print Witness Name Date