Natividad Medical Center
Financial Counseling Unit Application

Natividad
Inspiring healthy lives

Section 1: Applicant Information

First Name: _____ Middle: _____ Last Name: _____

DOB: _____ ☐ M ☐ F SSN#: _____ ITIN#: _____

Home Address: _____ City: _____ Zip Code: _____

Mailing Address: _____ City: _____ Zip Code: _____

Are you homeless? ☐ Yes ☐ No County/State in which you reside in: _____

Best contact number: ☐ Home ☐ Cell ☐ Work ☐ Message Number: ( ) _____ - _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Registered Domestic Partner

Are you a legal resident of the U.S.? ☐ Yes ☐ No Birthplace: _____

Are you pregnant? ☐ Yes ☐ No Expected delivery date: _____

Section 2: Household Information

List all the people currently living in your home: ***For additional household member(s), please notify worker.**

Name: _____ Relationship: _____ Minor? ☐ Yes ☐ No

Name: _____ Relationship: _____ Minor? ☐ Yes ☐ No

Name: _____ Relationship: _____ Minor? ☐ Yes ☐ No

Name: _____ Relationship: _____ Minor? ☐ Yes ☐ No

Do you pay rent or mortgage? ☐ Rent ☐ Mortgage ☐ None Your shared amount: _____

Are you receiving free housing or work in exchange for free housing? ☐ Yes ☐ No

Name of provider: _____ Relationship: _____

Section 3: Other Coverage Information

Have you applied for Medi-Cal benefits? ☐ Yes ☐ No If yes, date of application: _____

Case status: ☐ Pending/Date: _____ ☐ Approved/Date: _____ ☐ Denied/Date: _____

Do you have any other coverage? ☐ Yes ☐ No ***If yes, please check the options below that apply to you.**

☐ Health Insurance ☐ Medicare ☐ V.A. Insurance ☐ Auto Insurance ☐ Covered CA ☐ Emergency Medi-Cal

☐ Medi-Cal Share of Cost (SOC) ☐ Esperanza Care Program ☐ Other: _____

Section 4: Income Information

Are you currently employed? ☐ Yes ☐ No If yes, how often paid? ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Name of employer: _____

Is your spouse/partner employed? ☐ Yes ☐ No If yes, how often paid? ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Name of employer: _____

Are you or your spouse/partner self-employed? ☐ Yes ☐ No

Name of business: _____ Type of business: _____

Are you or your spouse/partner receiving income from the following: ***Please check the options below that apply to you.**

☐ Unemployment ☐ State Disability ☐ Social Security ☐ Worker's Compensation ☐ Pension ☐ Retirement

☐ Spousal Support ☐ Child Support ☐ Student Financial Aid ☐ G.A./Public Assistance ☐ Food Stamps ☐ None

Have you or your spouse/partner received a lump sum payment within the last two (2) years? ☐ Yes ☐ No
Lump sum amount: _____ Date received lump sum: _____
Do you or your spouse/partner file taxes? ☐ Yes ☐ No Tax year last filed: _____
If you did not file, please state the reason why: _____
Do you or your spouse/partner receive income from the following: ***Please check the options below that apply to you.**
☐ Home Property ☐ Commercial Buildings ☐ Private land ☐ Commercial Land ☐ None ☐ Other: _____
Do you or your spouse/partner have other income not listed above? ☐ Yes ☐ No
If yes, please describe: _____ How often paid? _____

Section 5: Asset Information

Do you or your spouse/partner own any bank account(s)? ☐ Yes ☐ No ***If you own multiple accounts, please notify worker.**
☐ Checking ☐ Savings Name of Bank: _____ Share account? ☐ Yes ☐ No
☐ Checking ☐ Savings Name of Bank: _____ Share account? ☐ Yes ☐ No
☐ Business Account Name of Bank: _____ Share account? ☐ Yes ☐ No
Do you or your spouse/partner own private properties, land(s), private building(s) or commercial building(s)? ☐ Yes ☐ No
If yes, have your or your spouse/partner sold or made a transfer within the last two (2) years? ☐ Yes ☐ No

Section 6: Medical Information

Reason(s) for applying for medical assistance:
☐ Labs ☐ Surgery Services
☐ Prescriptions ☐ Emergency Room Visit Date: _____
☐ Radiology Services ☐ In-Patient Services Date: _____
☐ Specialty Clinic Services ☐ Other: _____
What is your medical condition? _____
Have you had any injuries or accidents within the past five (5) years? ☐ Yes ☐ No
***If yes, describe your injury below. If more than one injury, please notify worker.**
☐ Auto Injury ☐ Work Injury ☐ Fall ☐ Assault ☐ Other: _____
Describe your injury: _____
Date of injury: _____ Are you pursuing any legal action? ☐ Yes ☐ No
Was there a settlement? ☐ Yes ☐ No Date of settlement: _____ Amount of settlement: _____

I declare under penalty of perjury that the above statements are true and correct. I understand that my statements are subject to verification. I also understand that if I give false statements or withhold information the applicant will be discontinued from the program and may be prosecuted for fraud.

Applicant's Signature: _____ Date: _____
Print Name: _____
Authorized Representative Signature: _____ Date: _____
Print Name: _____ Relationship: _____

Applicant Rights & Responsibilities

Persons Requesting Assistance Through the Natividad Financial Counseling Unit Have the Following Rights:

1. The right to request an interpreter.
2. The right to be treated fairly and equally regardless of age, sex, sexual orientation, race, economic status, disability, medical condition, educational background, marital status, registered domestic partner status, religion, ancestry, national origin or the source of payment for care.
3. The right to apply for financial assistance for medical care and to be informed in writing of non-approval for Financial Counseling Unit programs, even if the program representative determines that the applicant may not qualify.
4. The right to review information concerning Financial Counseling Unit programs.
5. The right to have all personal information given to the Financial Counseling Unit held confidential under the HIPAA Privacy Rule Act.
6. The right to appeal any action taken by the Financial Counseling Unit.

The Applicant Has the Responsibility to Notify the Financial Counseling Unit Within Ten (10) Days If:

1. The residence and/or mailing address of the applicant has changed.
2. An absent child or parent return to the home.
3. The applicant's domestic partner or wife becomes pregnant.
4. A minor child is adopted by the applicant or is awarded legal guardianship over a minor.
5. The applicant becomes physically or mentally impaired.
6. The applicant applies for Social Security benefits under the Department of Social Security Administration.
7. The applicant is awarded benefits through the: Department of Social Security Administration, Veterans Administration or under the Railroad Retirement Programs.

The Applicant Has the Responsibility to:

1. Apply for and provide a Social Security card.
2. Apply for health care resources that may be available to the applicant and notify a representative from the Financial Counseling Unit department of such application.
3. Apply for any income which may be available to applicant.
4. Report any health care coverage that the applicant is entitled to use or receives before using the eligibility under the Financial Counseling Unit program.
5. Report any injuries and accidents. This includes self-injuries, injuries under Worker's Compensation, Motor Vehicle Accidents, assaults, etc.
6. Report any health care services received as a result of an accident or injury caused by a third party.
7. Reimburse the county for health care services received through Monterey County programs when a payment has been received due to an injury or accident to which you are applying for assistance.
8. Provide legal documentation of a written authorization representing or acting on behalf of the applicant's private affairs, in case the applicant becomes unavailable or incoherent due to a medical reason.

Applicant's Declaration:

- I declare that the rights and responsibilities have been presented to me.
- I declare that I fully understand my responsibilities and will fulfill the requirements as mentioned above.
- I declare under penalty of perjury that the information on the application is true to the best of my knowledge.
- I understand that I may be asked to prove my statements and that my statements are subject to verification by my employer, personal banks, credit agencies, property searches, etc.
- I understand that if I deliberately make false statement or withhold any information, I will be discontinued from the program and/or prosecuted for fraud as a result of my actions.
- I understand that I may be contacted by a representative of the Financial Counseling Unit to start the process for a Medi-Cal application and that I will fully cooperate with Medi-Cal in the application process. Failure to do so, it may result in retroactive denial for the Financial Counseling Unit programs.
- I hereby authorize the Financial Counseling Unit to obtain and release medical, financial and eligibility information, necessary to determine eligibility, process claims or to perform utilization review and case management.
- A photocopy of this authorization shall be valid as the original.

Signature of Applicant: _____ Date: _____

Print Name: _____

Signature of Representative: _____ Date: _____

Print Name: _____ Relationship: _____

Signature of Eligibility Worker: _____ Date: _____

Print Name: _____ Title: _____