VENTURA COUNTY
HEALTH CARE AGENCY

Setting the Standard in Health Care Excellence

Sliding Fee Scale and Self-Pay Discount Programs 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 in making health care available to everyone in our community, regardless of their ability to pay. We offer an easy to qualify for Sliding Fee Discount Program (SFDP) and Self-Pay Discount Program (SPDP) to eligible patients. The SFDP has 4 pay discount levels and the SPDP has six pay discount levels based on individual or family income. You can request financial assistance if you, or your household income is at or below 200% of the Federal Poverty Level (FPL). Payment plans are available for families with incomes above 200% of FPL.

Sliding Fee Discount Program & Self-Pay Discount Program are available at:

PROGRAM AVAILABILITY LOCATIONS MARKED WITH ●

Program Number	% of the Federal Poverty Level	Sliding Fee Scale Program at Clinics	Self Pay Discount Program at Clinics	Self-Pay 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 350%	NOT AVAILABLE	●	●
6	greater than 350%	NOT AVAILABLE	●	●

Who is Eligible:

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

To Apply Please Submit Documents Below:

- Proof of income such as a W-2 form, paycheck stub or tax return.
- Personal/family bank and credit card account information (if any).
- Knowledge of household income and living expenses.
- Current medical bill information (if available).
- Identification (Driver's license, identification card, or passport).

If you need assistance with Sliding Fee Discount Program or Self Pay Discount Program policy requirements and/or the application, our clinic 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.

5851 Thille St. Ventura, California 93003 Tel: (805) 648-9553 Fax: (805) 677-5135 www.VCHCA.org

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Sliding Fee Scale - Self-Pay Discount 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 of 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 Other Wages Total Related to Work: Strike Benefits Unemployment Military Allotment	$
If applicable Retirement Related Income: Social Security Pensions IRA	$
Other (if any): Alimony/Child Support Dividends/Interest Disability Trust Account Interest Income Other	$

Check Proof of Income Attached: W-2 Form ☐ Pay Check Stub ☐ Tax Return ☐

**** Complete the Household Expenses section if household income is above 200% and a payment plan is needed for ** clinic services or if household income is less than or equal to 350% and a payment plan is needed for hospital services**

Household Expenses

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	$

Credit Card Company	Amount Paid Each Month	Credit Amount Available
	$	$
	$	$
	$	$
	$	$

Bank Account Information (if any)

Bank Name/Branch	Type of Account (Checking, Savings, Primary)	Account Number
		$
		$
		$

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 Self-Pay Discount Program Application and as provided by federal law, I the applicant/patient, request that VCHCA determine my eligibility for uncompensated services. 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