



**Financial Agreement of Medi-Cal & SSI Recipients for Admission**

Patient/Resident Name \_\_\_\_\_

1. I understand as a Medi-Cal patient at Laguna Honda Hospital (LHH), Department of Health Services (DHS) will assess my monthly income to determine if I have a share-of-cost (SOC) obligation to pay for my long-term care hospitalization at LHH. The formula for determining SOC is as follows: *Monthly income minus Personal Need Allowance minus Spouse Allocation (where applicable) = Share-of-Cost (monthly).*
2. I understand that as a Medi-Cal beneficiary, if I have a SOC obligation, my monthly income is subject to payment of my SOC and I will be entitled to retain \$35 each month for personal needs as required by the State.
3. I understand that it is my responsibility to report the whereabouts of my assets, including my Medi-Cal card, so that LHH eligibility staff can efficiently obtain Medi-Cal benefits for me.
4. I understand it is my responsibility to pay my SOC by the 5<sup>th</sup> day of each month. If my SOC is not paid timely, I realize I would not be complying with this agreement and items #7 and #9 below will immediately take effect. I understand that I have the option of my income being mailed directly to LHH for deposit into my Patient Trust Account and any SOC can be deducted automatically each month.
5. I understand that as a SSI recipient (where applicable) this benefit will be either: (a) reduced when there is no other income and my stay at LHH is for a complete month or (b) discontinued when other income exceeds \$25.00 per month and my stay at LHH is for a complete month. In the event of (b) above, an application for Medical Need Only (MNO) assistance will be initiated so that Medi-Cal will be continued.
6. I understand that LHH policy is to hold a bed up to 7 days if I am transferred to a general acute care hospital. I also understand that it is my right to exercise this bed hold provision and if desired, my legal representative or I will notify LHH within 24 hours of the transfer to hold the bed. I further understand that if I am not Medi-Cal eligible or covered by another insurance that will pay, I will be liable for the bed hold days at \$299 per day.
7. I acknowledge that any overdue unpaid debts are subject to further collection process through Bureau of Delinquent Revenue for City & County of San Francisco.
8. I understand that I am financially responsible for any hospital charges not covered by my insurance assignment and/or Medi-Cal if pending certification. Financial responsibility shall be binding on me and heirs, legal representative, executors and assignees.
9. I agree to comply with these conditions to avoid termination of plans for my admission.
10. During my stay at LHH, if I fail to comply with the terms of this agreement, I understand that I will be discharged from LHH. If eligibility questions need clarification, I will contact the Admissions & Eligibility Department of LHH.

I agree to the above stated conditions by my signature:

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Patient/resident or guardian or spouse or conservator  
or power-of-attorney or other legal representative

LHH Representative \_\_\_\_\_