Department of Public Health
Barbara A. Garcia, MPA, Director of Health

Edwin M. Lee
Mayor

Laguna Honda Hospital and Rehabilitation Center
Mivic Hirose, RN, CNS, Executive Administrator

Admissions and Eligibility Department

Private Pay Agreement for Admission to LHH

Patient/Resident Name: _____

1. As part of admission to Laguna Honda Hospital (LHH), I understand that as a private pay patient, I must pay a deposit that is equivalent to one month's daily rate. This deposit will be applied toward my first 30-day stay at LHH. I am responsible for the daily rate of $_____ plus any ancillary charges and professional fees not covered by any insurance.
2. I understand and agree to pay the daily rate in advance due on the 1st of each month and no later than the 5th day of that month. I understand that hospital ancillary charges and professional fees incurred for the month will be billed separately following the month of service. I will be responsible for payment of all services provided and billed to me each month. I agree to pay within 5 business days after receiving my LHH bill.
3. I agree to pay each monthly bill for long-term care hospitalization at LHH until I am discharged or my assets are within range to qualify for Medi-Cal benefits.
4. I understand and agree that if I am transferred to an acute hospital for care or take a leave of absence by pass orders from the physician, LHH will hold my bed upon my request. I further understand that for each day my bed is held a charge of $403.44 will be billed to my account.
5. I understand that it is my personal responsibility to inform the eligibility staff at LHH when my assets have reached $2,500 or less so an application for Medi-Cal can be initiated.
6. I understand that in the event I qualify for Medi-Cal benefits, I may be subject to a share-of-cost (SOC) depending upon my income. SOC is determined by Medi-Cal Department of Health Services based on the following formula: Monthly Income *minus* Personal Need Allowance *minus* Spouse Allocation (where applicable) *equals* SOC (monthly).
7. 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 for personal needs as the State requires.
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 my heirs, legal representative, executors and assignees.
9. I understand and agree that failure to comply with the terms of this agreement will result in termination of plans for admission to LHH, and if already admitted, will result in discharge from LHH.
10. I acknowledge that any overdue unpaid bills are subject to further collection process through Bureau of Delinquent Revenue for City & County of San Francisco.

I agree to the above stated condition by my signature

Date _____ Signature _____

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

Name of Guarantor _____ Contact # _____

LHH Representative _____