COUNTY OF LOS ANGELES•DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE (U-2) AGREEMENT FORM

GENERAL INFORMATION

If a Trauma Service County Eligibility (TSCE) (U-1) Agreement Form cannot be secured because the patient or the patient's responsible relative (s) (are) unable to cooperate to that effect, hospital must submit a copy of the completed and signed Attachment **'Hospital Certification of Inability to Cooperate (U-2) Agreement Form"** for each eligible patient's care if they are claiming reimbursement for Trauma Hospital funds under procedures set forth in Attachment "4", Trauma Service County Eligibility TSCE (U-1) Agreement Form Protocol.

NOTE: Patients **unwilling or refusing to cooperate** DO NOT qualify for this program.

Do not use Form (U-2) because TSCE form was mailed out and not completed nor returned by patient.

COMPLETION OF THE HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE (U-2) AGREEMENT FORM

1. TRAUMA SERVICE HOSPITAL/PHYSICIAN
   Enter Trauma Hospital where services where provided

2. MEDICAL RECORD NUMBER
   Enter Patient's Medical Record Number

3. DATE OF SERVICE
   Enter month, day, and year of service

4-6 PATIENT INFORMATION
   Enter patient's last name
   Enter first name
   Enter middle initial

7-10 PATIENT'S ADDRESS
   Enter patient's street address
   Enter city
   Enter state
   Enter zip code

11-12 PATIENT'S RESPONSIBLE RELATIVE(S) NAME
   Enter name of patient's Responsible Relative (s) (only If patient is unable to sign)
   Enter full address of patient's Responsible Relative(s)

INSTRUCTIONS FOR COMPLETION OF THE HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE (U-2) AGREEMENT FORM

13. SOCIAL SECURITY NUMBER
Enter patient's Social Security Number

14. TELEPHONE NUMBER
Enter patient's area code with telephone number

15. BIRTHDATE
Enter patient's birth date

16. REASON PATIENT UNABLE TO SIGN U-2
Explain why the patient was unable to sign the U-2

Key Points Indicate the patient's medical condition **Note:** If patient walks out of the facility, refuses, or is unwilling to sign the form, this claim will not be eligible for payment

17. HOSPITAL REVIEWER #1
Signature of Hospital Reviewer/Translator who obtained information

18. DATE
Signature and date should be at the time of patient registration

Key Points Ensure that the Hospital Reviewer signs and dates the form at the time it is determined that eligibility requirements have been met.

19. HOSPITAL REVIEWER #2
Signature of Hospital Reviewer's Supervisor and date

20 DATE
Date supervisor signed

This form or a Trauma Service County Eligibility (TSCE) (U-1) Agreement Form must be on file in the patient's financial chart

HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE (U-2) AGREEMENT

1 Trauma Service Hospital/Physician | 2 Medical Record Number | 3 Date(s) of Service

NOTE: Patients **unwilling or refusing to cooperate** DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION:

4 Last | 5 First | 6 Middle

7 Street | 8 City | 9 State | 10 Zip

11 Patient's Responsible Relative(s) Name(s) | 12 Addresses(s)

13 Social Security Number ___-___-___ | 14 Telephone Number ( )___-___ | 15 Birth date ___/___/___

WE CERTIFY UNDER PENALTY OF PERJURY BY OUR SIGNATURES THAT WE HAVE USED ALL REASONABLE MEANS TO DETERMINE THE PATIENT'S ELIGIBILITY IN ACCORDANCE WITH THE TSCE AGREEMENT. SPECIFICALLY, WE HAVE USED ALL REASONABLE MEANS TO:

1) Obtain the names and addresses of the patient and the patient's responsible relatives,

2) Obtain acceptable address verification, and

3) Obtain all information needed to complete the TSCE Agreement, including information regarding the income and family size of the patient and patient's responsible relatives, and the patient's third-party coverage.

16 The patient and/or patient's responsible relatives, if any, were UNABLE to cooperate fully because:

and TO THE BEST OF OUR KNOWLEDGE AND BELIEF, THE PATIENT OR PATIENT'S RESPONSIBLE RELATIVES ARE UNABLE TO PAY FOR THE COST OF HEALTH SERVICES PROVIDED AND THEPATIENT OR PATIENT'S RESPONSIBLE RELATIVES HAVE NO THIRD- PARTY COVERAGE FOR THESE HEALTH SERVICES. THE INFORMATION SET FORTH ABOVE IS ALL OF THE INFORMATION WEWERE ABLE TO OBTAIN WITH RESPECT TO THIS PATIENT.

17 Hospital Reviewer #1 | 18 Date ___/___/___

19 Hospital Reviewer #2 | 20 Date ___/___/___

THIS FORM MUST BE SIGNED BY TWO HOSPITAL STAFF VERIFYING THE REASON THE PATIENT AND/OR THE PATIENT'S RESPOPNSIBLE RELATIVES, IF ANY, WERE UNABLE TO COOPERATE AND SHOULD BE COMPLETED AT THE TIME OF REGISTRATION AND FINANCIAL INFORMATION IS COLLECTED FOR THIS ACCOUNT.

THIS FORM OR A TSCE MUST BE ON FILE IN THE PATIENT'S FINANCIAL CHART

HOSPITAL CERTIFICATION OF INABILITY TO COOPERATE (U-2) AGREEMENT

Trauma Service Hospital/Physician _____ Medical Record Number _____ Date(s) of Service _____

NOTE: Patients **unwilling or refusing to cooperate** DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION:

Last _____ First _____ Middle _____

Street _____ City _____ State _____ Zip _____

Patient's Responsible Relative(s) Name(s) _____ Addresses(s) _____

_____-_____-_____ Social Security Number ( )_____-_____ Telephone Number _____/_____/_____ Birth date

WE CERTIFY UNDER PENALTY OF PERJURY BY OUR SIGNATURES THAT WE HAVE USED ALL REASONABLE MEANS TO DETERMINE THE PATIENT'S ELIGIBILITY IN ACCORDANCE WITH THE TSCE AGREEMENT. SPECIFICALLY, WE HAVE USED ALL REASONABLE MEANS TO:

1) Obtain the names and addresses of the patient and the patient's responsible relatives,

2) Obtain acceptable address verification, and

3) Obtain all information needed to complete the TSCE Agreement, including information regarding the income and family size of the patient and patient's responsible relatives, and the patient's third-party coverage.

The patient and/or patient's responsible relatives, if any, were UNABLE to cooperate fully because:

_____

and TO THE BEST OF OUR KNOWLEDGE AND BELIEF, THE PATIENT OR PATIENT'S RESPONSIBLE RELATIVES ARE UNABLE TO PAY FOR THE COST OF HEALTH SERVICES PROVIDED AND THEPATIENT OR PATIENT'S RESPONSIBLE RELATIVES HAVE NO THIRD-PARTY COVERAGE FOR THESE HEALTH SERVICES. THE INFORMATION SET FORTH ABOVE IS ALL OF THE INFORMATION WEWERE ABLE TO OBTAIN WITH RESPECT TO THIS PATIENT.

_____ Hospital Reviewer #1 _____/_____/_____ Date

_____ Hospital Reviewer #2 _____/_____/_____ Date

THIS FORM MUST BE SIGNED BY TWO HOSPITAL STAFF VERIFYING THE REASON THE PATIENT AND/OR THE PATIENT'S RESPOPNSIBLE RELATIVES, IF ANY, WERE UNABLE TO COOPERATE AND SHOULD BE COMPLETED AT THE TIME OF REGISTRATION AND FINANCIAL INFORMATION IS COLLECTED FOR THIS ACCOUNT.

THIS FORM OR A TSCE MUST BE ON FILE IN THE PATIENT'S FINANCIAL CHART