



LOS ANGELES COUNTY - DEPARTMENT OF HEALTH SERVICES

OUTPATIENT REDUCED-COST SIMPLIFIED APPLICATION (ORSA) INFORMATION

If you can not pay for your outpatient medical care, tests or medicines, you may be eligible for the ORSA Program. You may not have to pay anything or only a small amount. ORSA is available for outpatient medical care, including emergency services, at any of the County hospitals and clinics listed on the other side of this page.

WHO IS ELIGIBLE?

- You must be a resident of Los Angeles County to receive ORSA.
- If you have no income or low income and do not have health insurance or a program that pays for outpatient medical care, you may be eligible for ORSA.
- If you can qualify for Medi-Cal, you apply for and cooperate with the Medi-Cal application before you can be considered for ORSA.
- If you are eligible for Medi-Cal but do not want to apply, you are not eligible for ORSA. However, you may use the Pre-Payment Plan. (See below.)

HOW TO APPLY:

- You must be a Los Angeles County resident and provide acceptable proof of address to receive ORSA.
- ORSA uses a one page application.
- Ask any County hospital or clinic financial staff about the ORSA program.
- In most cases, the financial worker will only need information about your family size and income. In other cases, the worker may ask you about your property and expenses.
- You will have to sign a form stating that what you say is true. You will not have to show additional proof (like pay stubs, income tax returns, bank statements, property tax statements, etc.) when you apply.
- However, a random number of patients will be asked later for some or all of this type of information, and a credit check may be done. If you are asked within 6 months of the time you apply to show proof of your income, (or property or expenses if this information was used for your ORSA application), and you do not, you may have to pay for the full cost of your outpatient medical care. You will have 20 days to give the information if you are asked.
- If you want ORSA, you have to apply for it within 6 months from the time you came in for outpatient medical care. ORSA will not cover any outpatient medical care which is more than 6 months prior to the date of your ORSA application. Exceptions to this rule will be made if you apply for ORSA because your Medi-Cal was denied. If you have any Los Angeles County outpatient medical bills that are over 6 months old, you may apply for Ability-to-Pay (ATP).
- You will get a copy of your ORSA Agreement which you need to bring with you each time you need outpatient medical care. You also need to bring your clinic card with you.

WHAT ORSA COVERS:

- ORSA covers **outpatient medical care** and medicines at the locations listed on the other side of this page **only**. You can **not** use ORSA for inpatient medical care.
- Your ORSA is good for 6 months. At the end of 6 months, you will have to apply again.

WHAT ABOUT OTHER PROGRAMS?

- You may use the low-cost "Pre-Payment Plan" instead of ORSA, if you are a Los Angeles County resident. In the Pre-Payment Plan, you pay from \$50 - \$200 for outpatient medical care, and you do not have to give any financial information. (The Pre-Payment Plan does not cover your medicines, so you may want to apply for ORSA.)
- If your cost for ORSA is more than the "Pre-Payment Plan" amount, you can pay the "Pre-Payment" amount instead.
- Please ask a financial worker to explain your payment choices and the regulations for the different programs. They will be glad to help you.
- If the worker says that you may be eligible for Medi-Cal, you can ask for help.
- US Citizenship and Immigration Services (USCIS) will **not** consider you a public charge if you are eligible for ORSA.
- If you have specific questions regarding public charge or other immigration issues, you may contact the Health Consumer Center of Los Angeles at 1 (800) 896-3203.
- For further information about ORSA and the County's other reduced cost programs, you may call a 24 hour recorded message at **1 (800) 378-9919**.

Hospitals

Harbor/UCLA Medical Center
1000 West Carson Street
Torrance 90509
(310) 222-2887

High Desert Multi-Service
Ambulatory Care Center
44900 North 60th Street West
Lancaster, 93536
(661)945-8440

LAC + USC Medical Center
2020 Zonal, Ground Floor
Los Angeles 90033
(323) 226-6361

Martin Luther King/Drew
Medical Center
12021 So. Wilmington Avenue
Los Angeles 90059
(310) 668-3564

Olive View/UCLA Medical
Center Outpatient Clinics
14445 Olive View Dr.
Sylmar 91342
(818)364-3077

Rancho Los Amigos National
Rehabilitation Center
7601 E. Imperial Hwy.
Downey, 90242
(562)401-7320

Comprehensive Health Centers

El Monte Comp. Health Center
10953 Ramona Boulevard
El Monte 91731
(626) 579-8412

E.R. Roybal Comp. Health Ctr.
245 So. Fetterly Avenue
Los Angeles 90022
(323) 780-2340

H.C. Hudson Comp. Health Ctr.
2829 South Grand Avenue
Los Angeles. 90007
(213) 744-3689
(213) 744-3821 (after 5:00 p.m.)

H.H. Humphrey
Comp. Health Center
5850 So. Main Street
Los Angeles 90003
(323) 846-4287

Long Beach Comp. Health Ctr.
1333 Chestnut Avenue
Long Beach, 90813
(562) 599-8704

Mid Valley Comp. Health Center
7515 Van Nuys Blvd.
Van Nuys 91405
(818) 947-4000

Health Centers

Antelope Valley Health Center
335-B E. Ave. K-6
Lancaster 93535
(661) 723-4511

Bellflower Health Center
10005 E. Flower St.
Bellflower 90706
(562) 804-8111

Dollarhide Health Center
1108 N. Oleander
Compton 90220
(310) 763-2244

Glendale Health Center
501 N. Glendale Ave.
Glendale 91206
(818) 500-5785

Lake Los Angeles
16921 E. Avenue O, Space G
Lake Los Angeles 93535
(661)945-8442

La Puente Health Center
15930 Central Ave.
La Puente 91744
(626) 855-5300

Littlerock Health Center
8201 Pearblossom Hwy.
Littlerock 93543
(661) 945-8381

South Valley Health Center
38350 40th St. East
Palmdale 93550
(661)272-5010

San Fernando Health Center
1212 Pico St.
San Fernando 91340
(818) 837-6969

Wilmington Health Center
1325 Broad Ave.
Wilmington 90744
(310) 518-8800

**COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
OUTPATIENT REDUCED-COST SIMPLIFIED APPLICATION (ORSA) PLAN
(Please Print)**

Facility: _____ MRUN # _____ Outpatient Visit Date(s): _____

SECTION I: PATIENT INFORMATION

Patient: _____ DOB: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: [Home] (____) _____ [Work] (____) _____ [Message] (____) _____
Los Angeles County Resident Yes No (Ineligible)

SECTION II: INCOME INFORMATION:

How many family members are in your household? _____
Grand Total Monthly Net Income - [Enter from Worksheet, Part A or F, Line 4]: \$ _____

SECTION III: ORSA LIABILITY: (County Use Only - To Be Completed by Interviewer)

ORSA Liability Per Visit: _____ Dollars (\$ _____)
[Enter from Worksheet, Part B.]
Patient Eligibility Period: From _____ to _____

SECTION IV: ORSA CERTIFICATION

I certify that, as of today's date, I, (or patient), do/(does) not have Medi-Cal, Medicare, Short Doyle, CHAMPUS, California Children Services, or private health insurance, etc. for the condition for which the patient is being treated. During the next six months, if I get or lose insurance, or if my family size or income changes, I promise to immediately report that fact to the facility where this form was completed.

I further certify and declare under penalty of perjury under the laws of the State of California that the information I have provided is true and complete. I understand that a random number of patients will be asked later for proof of some or all of the information used for this application and that a credit check may be done. I understand that I am expected to save documents I might have that would help prove that what I said today is true, (for example, copies of pay stubs, income tax returns, bank statements, property statements, receipts, etc.), for 6 months from the date of this application. If I am asked for these documents in the next 6 months, I will have 20 days to mail or bring the information to the facility or to give some other acceptable verification. If I am asked for this proof and don't provide it, I may be held responsible for the full charges for my medical care.

I understand that, if I am eligible, this plan will cover outpatient health care services, (including pharmacy), except for cosmetic surgery, at all Los Angeles County Department of Health Services' medical care facilities, including hospital outpatient, comprehensive health centers, and health centers.

I agree to pay the County for each outpatient visit covered by this agreement from _____ to _____ the ORSA liability amount as indicated in Section III.

Patient/Responsible Relative Signature: _____ Date: _____

County Interviewer: (Print Name) _____ Telephone No.: (____) _____

(Signature) _____ Date: _____

(Supervisor's Signature) _____ Date: _____

Check box, if applicable
Patient has approved restricted Medi-Cal. This ORSA will cover only services that do not meet the Medi-Cal definition of emergency / pregnancy related services.