San Bernardino Mountains Community Hospital District
Charity Care Application

INSTRUCTIONS

1. Please complete *all* areas on the attached application form. If any area does not apply to you, write N/A in the space provided.

2. Attach an additional page if you need more space to answer any question.

3. You *must* provide proof of income documents when you submit this application. The following documents are accepted as proof of income:

   If you filed a federal income tax return you must submit a copy of:
   a. Federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service;

   If you did not file a federal income tax return, you must submit the following:
   a. Two (2) most recent paycheck stubs; **and**
   b. A letter explaining why you do not file a federal income tax return.

   If you have no income, or proof of income documents, you must provide a letter explaining how you support yourself/family. The Hospital will take this into consideration.

4. Your application cannot be processed until *all* required information is provided.

5. It is important that you complete and submit the financial assistance application along with all required attachments within fourteen (14) days.

6. You *must* sign and date the application. If the patient/guarantor and spouse provide information, both *must* sign the application.

7. If you have questions, please call your account representative.

8. Send your completed application to:

   San Bernardino Mountains Community Hospital District
   Patient Financial Services Department
   Attn: Customer Service
   PO Box 70
   Lake Arrowhead, CA 92352

San Bernardino Mountains Community Hospital District
Charity Care Application

PATIENT/ GUARANTOR NAME		**SPOUSE NAME**	
Address		**Home Phone**	
		Work Phone	
SOCIAL SECURITY NUMBER			
Patient/ Guarantor		**Spouse**	

Please list MCH account numbers to be considered for charity care:				

FAMILY STATUS
List all dependents that you support

Name	Age	Relationship

EMPLOYMENT STATUS	
Patient/Guarantor Employer	**Position**

Contact Person	**Telephone**
Spouse Employer	**Position**
Contact Person	**Telephone**

INCOME		
	Patient/Guarantor	**Spouse**
1. Gross Wages & Salary/Year (before deductions)		
2. Self-Employment Income/Year		
3. Other Income:		
3. Interest & Dividends		
4. Real Estate Rentals & Leases		
5. Social Security		
6. Alimony		
7. Child Support		
8. Unemployment/Disability		
9. Public Assistance		
10. All Other Sources (attach list)		
Total Income (add lines 1 - 10 above)		

UNUSUAL EXPENSES	
Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (attach list as needed).	
Description	**Amount**

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Hospital District to verify any information listed in this application. We expressly grant permission to contact my/our employer.

_____ _____

Signature of Patient/Guarantor Signature of Spouse

_____ _____

Date Date