MOUNTAINS COMMUNITY HOSPITAL
The Heart of Mountain Healthcare

SAN BERNARDINO MOUNTAINS COMMUNITY HOSPITAL DISTRICT (SBMCHD)
CHARITY CARE AND DISCOUNT PAYMENT 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 year in which the patient was first billed or 12-months prior to when the patient was first billed. You must include all schedules and attachments as submitted to the Internal Revenue Service.

   If you did not file a federal income tax return, please provide the following:

   a. Two (2) recent paystubs within a 6-month period before or after the patient is first billed by the hospital, or in the case of preservice, when the application is submitted.

   If you have no income, or proof of income documents, we request that you please provide a letter explaining how you support yourself/family.

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

5. It is important that you complete and submit your application along with all required attachments as soon as possible so that SBMCHD may determine your eligibility. Eligibility may be determined at any time SBMCHD is in receipt of documentation.

6. You must sign and date your application. If the patient/responsible party and spouse provide information, both must sign the application.

7. If you have questions, please call the Eligibility Office at (909) 436-3125.

8. Send your completed Financial Assistance Application and all documents to:
   San Bernardino Mountains Community Hospital District
   Eligibility Office
   P. O. Box 70
   Lake Arrowhead, CA 92352

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CHARITY CARE AND DISCOUNT PAYMENT APPLICATION

The purpose of this form is to determine patient/responsible party eligibility for financial assistance in accordance with the San Bernardino Mountains Community Hospital Distrct Charity Care and Discount Payment Policy.

PATIENT NAME: _____

RESPONSIBLE PARTY (guarantor) NAME: _____

SPOUSE NAME: _____

ADDRESS: _____

HOME PHONE: _____

CELL PHONE: _____

PATIENT SOCIAL SECURITY NUMBER: _____

RESONSIBLE PARTY (guarantor) SOCIAL SECURITY NUMBER: _____

SPOUSE SOCIAL SECURITY NUMBER: _____

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 _____

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SAN BERNARDINO MOUNTAINS COMMUNITY HOSPITAL DISTRICT (SBMCHD)
CHARITY CARE AND DISCOUNT PAYMENT APPLICATION *continued*

INCOME

	Patient/Guarantor	Spouse
1. **Gross Wages & Salary/Year** (before deductions)	$	$
2. **Self-Employment Income/Year**	$	$
3. **Other Income:**		
a. **Interest & Dividends**	$	$
b. **Real Estate Rentals & Leases**	$	$
c. **Social Security**	$	$
d. **Alimony**	$	$
e. **Child Support**	$	$
f. **Unemployment/Disability**	$	$
g. **Public Assistance**	$	$
h. **All Other Sources (attach list)**	$	$
Total Income (add lines 1 - 3h 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 SBMCHD to verify any information listed in this application. I/we expressly grant permission to contact my/ our employer.

_____ _____

Signature of Patient/Responsible party **Relationship to Patient** **Date**

Signature of Spouse **Date**