Redlands Community Hospital

Redlands Community Hospital
Financial Assistance Application

1. Please complete *all* areas on the attached application form. If any areas do 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 identity. (Only one person in a family needs to provide an identity document) The following documents are accepted as proof:

    - California driver's license
    - Identification card issued by the department of Motor Vehicles
    - U.S. citizenship or alien status documents (passport)
    - Social Security card or document containing a Social Security number

4. You *must* provide proof of income when you submit this application. The following documents are required:
    - Tax Return (A-1)
    - Two most recent pay stubs. (If a pay stub is not available, get a signed statement from your employer. Gross monthly income and the dates received should be on the statement.)

    (A-1) If you filed a federal income tax return you <u>must</u> submit a copy of:
    - 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;
    - Federal W-2 form showing wages and earnings;

    If you did not file a federal income tax return, please provide the following:
    a. Two (2) most recent pay check stubs; and
    b. Two (2) most recent stubs from any Social Security, unemployment, disability, child support, alimony, or other payments;
    c. Two (2) consecutive bank statements.
    d. If you are paid only in cash, please provide a written statement explaining your income sources;
    e. A letter explaining why you do not file a federal income tax return.

    If you have no income, please provide a letter explaining how you support yourself/family and who support you. If someone is supporting you, that person will need to write a letter of support.

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

6. It is important that you complete and submit the application along with all required attachments within thirty (30) days.

7. You *must* sign and date the application.

8. If you have any questions, please call (909) 335-5534 x: 5580

9. Send your completed application to:

   Redlands Community Hospital
   Business Office
   Po Box 10518
   San Bernardino, Ca 92423

Application Instructions

(SECTION 1)
Tell us about the patient who is interested in Financial Assistance.

Questions 1-2:
Do you have insurance? Answer yes or no. If yes, enter name of insurance.

Question 3:
If this visit is due to an accident, answer "yes"; otherwise answer "no".

Questions 4-11:
Enter the name, home address and telephone numbers of the person who is interested in Financial Assistance.

Questions 12-16:
Enter the phone number and mailing address (if different than home address provided in #2) of the person who wants Financial Assistance. This is the address where all information regarding the application will be mailed.

(SECTION 2)
Tell us about the person listed in Section 1, his or her family or dependants.

Who counts as an adult?

- Persons 21 years of age or older
- Person under 21 years of age who are not living in the home of their parent or caretaker relative and are not claimed as tax dependants

Who counts as a dependant?

- All natural and adoptive children under 21 living in the home.
- Any family member over the age of 21 that can be claimed as tax dependants.

Question 17:
Write the last, first and middle name of each person in the house.

Question 18:
How is each person related to the person in Section 1. Example: self, wife, husband, grandparents, friend, daughter, stepchild, nephew, etc.

Question 19:
Write the complete address, if different from the address in Section 1. Example: child is in college and living at school.

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Question 20:
Enter the social security # of persons over 21.

Question 21:
Indicate the marital status of each person listed.

Question 22:
Write month, day and year of birth for each person.

(SECTION 3)
List *ALL* income/money received by person listed in Section 2.

Questions 23 and 24:
Use a separate line for each person who receives money. If a person receives money from two different places, use two lines.

Example: if the applicant has two jobs, use one line for each job to report her/his earnings.

Question 25: Write the amount of the money you receive each time.
Example: if you get money once a week, write the weekly amounts in the box.

If the money amount changes from time to time, put the average amount you get on a regular basis. We use pay stubs or other documents you give us to figure out the correct monthly income.

Question 26: How often do you receive this money?

Example: Monthly (once a month); weekly (once-a-week); biweekly (every other week); bimonthly (twice a month); or daily (every day).

Signature and certification is required. Your signature in this section indicates that your declarations and answers are truthful and the documents you submit are true and correct.

APPLICATION FOR FINANCIAL ASSISTANCE

Print clearly. Use black or blue ink only. Acct #____________________

(SECTION 1) Tell us about the patient who is interested in Financial Assistance

1) DO YOU HAVE INSURANCE?	2) IF SO, NAME OF INSURANCE:	3) IS THIS VISIT DUE TO AN ACCIDENT?	
4) LAST NAME	FIRST NAME		MIDDLE INITIAL
5) HOME ADDRESS (NUMBER AND STREET). DO NOT LIST A P.O. BOX UNLESS HOMELESS		6) APARTMENT NUMBER	7) HOME PHONE # ( )
8) CITY/STATE	9) COUNTY	10) ZIP CODE	11) WORK PHONE # ( )
12) MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX		13) APARTMENT NUMBER	14) MESSAGE PHONE # ( )
15) CITY			16) ZIP CODE

(SECTION 2) Tell us about the person listed in Section 1, his or her family or dependants.

	Adult 1/Self	Adult 2	Dependant 1	Dependant 2	Dependant 3
17) Name: Last					
First					
Middle					
18) Relationship to person in Section 1.					
19) If address where living is not the same as listed in Section 1, put address where living:					
20) Social Security #					
21) Marital Status:					
22) Date of Birth:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR

(SECTION 3) List *ALL* income/money received by persons listed in Section 2.

23) NAME OF PERSON RECEIVING INCOME/MONEY	24) SOURCE OF INCOME/ MONEY RECEIVED (Employment, Social Security)	25) HOW MUCH INCOME/MONEY IS RECEIVED	26) HOW OFTEN INCOME/ MONEYRECEIVED (Monthly, bimonthly, weekly, biweekly, daily)

I hereby certify that the above listed information submitted is true to best of my knowledge and belief.

Signature Date