400 N. Pepper Avenue, Colton, California 92324-1819 | Phone: 909.580.1000

www.arrowheadmedcenter.org

The Heart of a Healthy Community

ARMC
400 N PEPPER AVE
COLTON CA 92324
1-877-818-0672
ATTN: PATIENT ACCOUNTS DEPARTMENT

In order to make your application complete, the following documentation must be included:

- **PROOF OF DENIAL FROM MEDI-CAL (if applicable)**
- **COPY OF PICTURE IDENTIFICATION**
- **PROOF OF INCOME**
- **PROOF OF SPOUSES INCOME (if applicable)**
- **STATEMENT OF SUPPORT IF THERE IS NO INCOME**

Failure to submit all required documentation with the application will result in an incomplete application.

The application process takes approximately 30 days from the date the application is received.

FAILURE TO COMPLY WITH THE QUALIFICATION REQUIREMENTS FOR ANY GOVERNMENT ASSISTANCE PROGRAM WILL RESULT IN FINANCIAL ASSISTANCE DENIAL.

Please be advised that this application is for <u>Arrowhead Regional Medical Center (ARMC) Charges only and coverage does not apply to the Professional Fees incurred, such as Physicians, Radiology, Laboratory, etc.</u> THESE CHARGES WILL BE YOUR FINANCIAL RESPONSIBILITY.

Arrowhead Regional Medical Center maintains a list of non-covered providers you can find it online at https://www.arrowheadmedcenter.org/pvBilling.aspx or you may request a copy by calling Patient Accounts department 1-877-818-0672.

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FINANCIAL ASSISTANCE PROGRAM
STATEMENT OF FINANCIAL CONDITION

PATIENT NAME ________________________________ **SPOUSE** ______________________

ADDRESS _______________________________________ **PHONE** ______________________

CITY ______________________________**STATE** _________ **ZIP CODE** ________________

MR#/V# ______________________ **SS#**______________________ **SS#**___________________
(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support
(If additional space is needed please use page 5)

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION

Employer: ____ **Position:** ___________________

Contact Person and Telephone: ____

If self-employed, Name of Business: ____

Spouse's Employer: _________________________________ **Position:** ___________________

Contact Person and Telephone: ____

If self-employed, Name of Business: ____

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CURRENT MONTHLY INCOME

	Patient	Spouse
Gross Pay (before deductions)	____________________	____________________
Section A (Income-Unearned):		
Social Security Pension	____________________	____________________
Retirement or VA benefits	____________________	____________________
Unemployment	____________________	____________________
State Disability Insurance (Temporary)	____________________	____________________
Alimony or Child Support Payments Received	_____________________	__________________
Other (specify) ___________________________	_____________________	__________________
Total Income:	_____________________	__________________
Section B:		
Alimony, Child Support Payments Paid	_____________________	__________________

Please circle one:

Do you have Insurance: **YES OR NO**
Are you eligible for MEDICARE: **YES OR NO**
Are you Eligible for MEDI-CAL: **YES OR NO**
Are you eligible for government programs: (i.e. Victims of Crime, Medi-Cal, Healthy Families, or California Children Services (CCS), etc) **YES OR NO**

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PLEASE AGREE TO THE FOLLOWING INFORMATION

- **I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.**
- **I agree to allow Arrowhead Regional Medical Center to check my employment for the purpose of determining my eligibility for a financial assistance.**
- **I understand that the information submitted on this application is subject to verification which may include a credit check.**
- **I understand that I may be required to provide proof of the information I am providing.**
- **I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the County from the proceeds of any litigation or settlement resulting from such act.**

______________________________	___________	___________________________	___________
(Signature of Patient or Guarantor)	**(Date)**	**(Signature of Spouse)**	**(Date)**

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Additional Space for comments:

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