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 Arrowhead Regional Medical Center (ARMC) Charges only and coverage does not apply to the Professional Fees incurred, such as Physicians, Radiology, Laboratory, etc. 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.
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: __________________________________________
# CURRENT MONTHLY INCOME

<table>
<thead>
<tr>
<th></th>
<th>Patient</th>
<th>Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross Pay (before deductions)</strong></td>
<td>_________</td>
<td>_________</td>
</tr>
<tr>
<td><strong>Section A (Income-Unearned):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Pension</td>
<td>_________</td>
<td>_________</td>
</tr>
<tr>
<td>Retirement or VA benefits</td>
<td>_________</td>
<td>_________</td>
</tr>
<tr>
<td>Unemployment</td>
<td>_________</td>
<td>_________</td>
</tr>
<tr>
<td>State Disability Insurance (Temporary)</td>
<td>_________</td>
<td>_________</td>
</tr>
<tr>
<td>Alimony or Child Support Payments Received</td>
<td>_________</td>
<td>_________</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>___________________</td>
<td>_________</td>
</tr>
<tr>
<td><strong>Total Income:</strong></td>
<td>___________________</td>
<td>_________</td>
</tr>
</tbody>
</table>

**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**
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)
Additional Space for comments: