SAN GORGONIO
MEMORIAL HOSPITAL

AUTHORIZATION FOR CHARITY CARE WRITE OFF

CEO	$50,000.00 and up
CFO	$10.001.00 up to $49,999.99
PFS Director	$10,000.00 and below

Approval signature(s)

Patient name: _____

Account Number(s): _____

Total Charity Discount: _____

Date: _____

SAN GORGONIO
MEMORIAL HOSPITAL

PATIENT NOTICE OF FINANCIAL ASSISTANCE

FOR LOW INCOME OR UNINSURED FAMILIES

San Gorgonio Memorial Hospital is proud of its mission to provide quality care to all who need it, regardless of the ability to pay.

If you do not have health insurance and worry that you may not be able to pay in full for your care, we may be able to help you. San Gorgonio Memorial Hospital provides financial assistance to patients based on their income, assets and needs. Through our financial counseling services we may be able to get you qualified for financial coverage with free or low-cost health insurance, or work with you to arrange a manageable payment plan.

In addition, in compliance with California Assembly Bill 774, which was effective January 1, 2007, you may qualify for a discount on your hospital bill if you are a financially qualified patient. Information on our charity and discount policy is available at your request. Also, effective January 1, 2011 an amendment was passed through AB 1503, which now allows for the availability of charity care and discounted payments for the emergency room physician fees, which are separate from the San Gorgonio Memorial Hospital billing.

It is important that you let us know if you will have trouble paying your bill. Federal and State laws require all hospitals make reasonable efforts to collect payment for services from patients. The hospital may turn unpaid bills over to a collection agency, which could affect your credit status. We would like to work with you to avoid this situation.

For more information, please contact the Business Office at (951)769-2172 or (951)769-2189.

We will treat your questions with confidentiality and courtesy.

SAN GORGONIO MEMORIAL HOSPITAL
STATEMENT OF FINANCIAL CONDITION

PATIENT NAME_____SPOUSE NAME _____

ADDRESS_____PHONE _____

PATIENT SSN_____ SPOUSE SSN _____

FAMILY STATUS: List all dependents that you support:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT AND OCCUPATION

Employer:_____ Position_____

Contact Person & Telephone_____

If self employed, Name, address and type of Business_____

_____

CURRENT MONTHLY INCOME

ADD: Patient Spouse

_____ _____

Gross Pay (before deductions) _____ _____

Income from Operating Business (if self employed) _____

OTHER INCOME: Patient: Spouse:
ADD:

Interest and Dividends _____ _____

From Real Estate _____ _____

Personal Property _____ _____

Social Security _____ _____

Alimony or Support Payment _____ _____

SUBTRACT:
Alimony, Support Payment Paid _____ _____

Equals: Current Monthly Income_____ _____

IN ADDITION PLEASE PROVIDE:

- 2 recent paycheck stubs, disability or unemployment check copies or the most current tax return if currently unemployed/self employed.
- Proof of residence (utility bill, mail)
- 2 Recent bank statement(s) for **all** accounts (i.e. checking and savings)
- Proof of citizenship (i.e. driver's license, social security card)
- And Description of hardship letter (i.e. loss of employment, etc.)
- Determination letter from Medi-cal/MISP, Riverside County Health etc. if applicable

By signing this form, I agree to allow San Gorgonio Memorial hospital to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand I will be required to provide proof as stated above.

_____ _____

Signature of Patient or Guarantor Date

_____ _____

Signature of Spouse Date