



Instructions for Application for Discount/Charity

Please read before beginning application.

(SECTION 1)

Tell us about the patient who is interested in Discount/Charity.

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 Discount/Charity.

Questions 12-16:

Enter the phone number and mailing address (if different than home address provided in #2) of the person who wants Discount/Charity. This is the address where all information regarding the application will be mailed.

Send proof of identity. Only one person in a family needs to provide an identity document. Send a photocopy of one of the following identity items:

- California driver 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

(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.

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).

Documentation of Income

- Send proof of income. Send a copy of the two most recent pay stubs you have. 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 copy of last year's federal income tax return.

OR

Other proof of income you may need to send:

- If a person is self-employed, send last year's federal income tax return, include Schedule C or F, or the last 3 months' profit and loss statements.
- If a person has income such as disability or retirement, send copies of award letters or bank statements showing the direct deposits.
- If anyone gets child support and/or alimony or spousal support, send copies of the checks received or statements from the District Attorney's Family Support Division for the last month.

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.

Mail the Application for Discount/Charity, proof of income, and proof of identity to:

**Redlands Community Hospital
Business Office
PO Box 10518
San Bernardino, CA 92423**

Application must be returned within 10 days. For any assistance or questions, please call **(909) 335-5580**, Monday – Friday 7:30AM – 4:00PM.



TAKE NOTICE OF THE FOLLOWING

1. Include your complete Tax return forms from last year if any and also include your W-2 forms.
 - a. If you did not file a tax return, you will need to explain why.
2. Include proof of income, if any.
 - a. If you do not have proof of income, you will need to write a letter and explain how you live and who supports you.
 - b. If someone is supporting you then that person will need to write a letter of support.
3. Place a copy of your ID with Application

Please read all directions carefully, if you have any further questions or are in need of assistance please contact our office.

Monday- Friday 7:30 am – 4:00 pm; (909) 335-5580.

Christine Galich
Patient Account Representative
Redlands Community Hospital, Business Office



APPLICATION FOR CHARITY

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

(SECTION 1) Tell us about the patient who is interested in Administrative Adjustment

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/MONEY RECEIVED (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 _____