CORONA REGIONAL MEDICAL CENTER

This letter is to inform you that you have an outstanding balance with Corona Regional Medical Center. To help meet your obligation to us, we are providing you with this application for financial assistance.

Corona Regional Medical Center has a program to assist patients with their financial obligations. If eligible, this program will help uninsured, low-income patients with payment of their hospital bills.

Eligibility under this program is based upon certain criteria which includes, but is not limited to:

- The program does not pay for Physician or other medical provider bills.
- There is not actual payment made to the Hospital from any other source
- The patient may not be eligible for any other Federal, State or Third Party Insurance
- Monthly income that is at or below 350% of Federal Poverty Guidelines.

The following information is needed to begin the application process:

- Completed Application
- Signed Authorization for consent for release of information
- Copies of most recent IRS tax return or copies of last 2 pay stubs
- Medi-Cal /SSI denial letter (if applicable)
- Proof of Income from SSA (if applicable)
- Proof of Income from Disability Program (if applicable)
- Means of support letter (written by whomever is supporting you)
- Copies of last 2 bank statements
- Copies of Unemployment statement (if applicable)

<u>If an application is incomplete, lacks above documentation, or is not returned to us within 30 days, your application will be denied.</u>

Once received, your application will be processed and our determination will be sent to you by mail.

Thank you,

Customer Service
UHS Pacific Region CBO
(866) 221-1977

UHS Pacific Region CBO
38977 Sky Canyon Dr., Ste.200
Murrieta, CA 92563

CORONA REGIONAL MEDICAL CENTER

FINANCIAL STATEMENT SUMMARY

Facility:Corona Regional Medical Center

Patient Name: Patient Number:
Total Charges:$ Date of Service:
Deceased Homeless Date of Assign:

Coverage

To provide consideration for financial assistance, it is necessary that all other payer resources have been exhausted. Please identify that the patient has been screened, and deemed ineligible for the following potential programs:

☐ Medicaid/ Meid-cal ☐ Disability ☐ Supplemental Security Income
☐ Insurance Coverage ☐ Third party Liability ☐ CCS/CDIC
☐ County Program-MISP ☐ Victims of Violent Crimes ☐ Workers' Compensation

If a partial payment has been made, it is to be deducted from total charity discount recommended:
Amount Paid: $ By whom:

Income/Expense Verification

Please identify that income and expenses have been verified.
☐ *Income Verified. Source:*
☐ *Absence of income attestation. Completed by:*
☐ *Statement of assets. (Bank statement copies, etc.)*
☐ *Mortgage / Rent statements*
☐ *Other living expenses. (Copies of utility bills, Auto, Insurance)*

Patient/ Guarantor Signature:_____ Date:_____ Phone_____

Representative Signature:_____ Date:_____

For office use only

Meets Federal Poverty Guidelines: ☐ Yes ☐ No

Amount of Reduction to Patient Balance: $_____

Eligible for Catastrophic Consideration? ☐ Yes ☐ No

Manager/Director Approval:_____ Date:_____

CONFIDENTIAL FINANCIAL STATEMENT

Patient Name:	Facililty:
Patient Number:	DOS:

RESPONSIBLE PARTY

Name:	Marital Status:	Social Security Number - -
Street Address, City, State, Zip	How long at this address	Home Phone ( ) -
Employer Name and Address (If unemployed-How long?)		Business Phone ( ) -
Position / Title:	Monthly Income—Gross $	Monthly Income—Net: $
		Length Of Employment Num. of Years:_____

DEPENDENTS

Name & Year of birth for all Dependents in household: _____ _____ _____	Total number of all dependents in household: _____	Do any other persons contribute? If yes, include amount. _____Yes/No Amount:$_____

INCOME PER MONTH & ASSETS

Dividends, Interest	$	Child Support / Alimony	$
Public Assistance/Food Stamps	$	Rental Income	$
Social Security	$	Grants	$
Unemployment Compensation	$	IRA	$
Workers Compensation	$	Other	$
Savings	$		$

EXPENSES PER MONTH

Mortgage / Rent Payment	**$**	Medical/Dental	**$**
Own Home? (Yes/No)		Doctor-Name	$
Food	**$**	Doctor-Name	**$**
Utilities:		Doctor-Name	**$**
Electric	**$**	Credit Cards:	
Gas	**$**	Visa Limit	**$**
Water/Sewer	**$**	Master Card Limit	**$**
Trash	**$**	Discover Limit	**$**
Phone	**$**	Amex Limit	**$**
Cable	**$**	Other Limit	**$**
Auto Payments	**$**	Installment Loans	**$**
Auto Expenses	**$**	Child Support	**$**
Insurance:		Miscellaneous Expenses	**$**
Auto Premium	**$**		**$**
Life Insurance	**$**		**$**
Health Insurance	**$**		

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Gross Income:$_____
Net Income:$_____
Total Expenses:$_____
Total Net Income (loss):$_____

To my knowledge the information above is true. I authorize a Credit Bureau Report to be secured by the hospital or its agents to verify my financial standings.

_____
PATIENT/GUARANTOR SIGNATURE DATE