EISENHOWER MEDICAL CENTER

Financial Assistance Application Instructions

If you do not have insurance coverage, you may be eligible for charity care or other hospital discount. Any individual, whose family income is at or below 350% of the Federal Poverty Level, may be eligible for discounted services under the hospital's charity care policy. In addition, patients without insurance coverage may be eligible for government programs such as Medi-Cal, County Indigent and other government funded healthcare assistance programs. Or you are welcome to obtain applications for coverage offered through the California Health Benefit Exchange: www.coveredca.com or through the Riverside Department of Public Social Services at (800) 274-2050 or http://dpss.co.riverside.ca.us.

1. Please complete *all* areas on the attached application form. If any area does not apply to you, please write N/A (not applicable) in the space provided.

2. Attach an additional page if you need more space to answer a question.

3. You *must* provide proof of income when submitting this application. The following documents are accepted as proof of income:

   If you filed a federal income tax return, you must submit a copy of:

   a. Prior year Federal Income Tax Return (ex. form 1040) and should include all schedules and attachments, as submitted to the Internal Revenue Serves (IRS); **TAXES AND LETTER OF EXPLANATION.**

   If you did not file a federal income tax return, please provide the following:

   a. Two (2) most recent paycheck stubs; and

   b. A letter explaining why you do not file a federal income tax return, and

   c. Two months of current bank statements for checking and saving accounts.

   If you have no income, please provide a letter explaining how you support yourself/family.

4. **You must provide proof of monetary assets,** such as two (2) current bank statements and the documents that indicate amounts owned by the patient or family representative.

5. Your application cannot be processed until *all* required information is provided. It is important that you complete and submit the financial assistance application along with all required documentation **within 14 days.**

6. You *must* sign and date the applications. If the patient/guarantor and spouse provide information, both *must* sign the application.

7. If you have questions, please call your account representative at **760- 837-8376**.

8. Send your completed application to:

   Eisenhower Medical Center
   Attn: Patient Financial Services Department – Financial Assitance
   39000 Bob Hope Drive
   Rancho Mirage, CA 92270
   Fax 760- 773-4317

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PATIENT FINANCIAL ASSISTANCE APPLICATION

ACCOUNT/MEDICAL RECORD #: _____

RESPONSIBLE PARTY NAME: LAST FIRST MIDDLE	
PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY:	SOCIAL SECURITY #:
ADDRESS:	PHONE:
CITY, STATE & ZIP:	WORK/CELL PHONE:
EMPLOYER: CONTACT PERSON/PHONE #	OCCUPATION:

SPOUSE INFORMATION

NAME: LAST FIRST M.I.	SOCIAL SECURITY #:
ADDRESS:	PHONE:
CITY, STATE & ZIP:	WORK/CELL PHONE:
EMPLOYER: CONTACT PERSON/PHONE #:	OCCUPATION:

LIST ALL DEPENDENTS

NAME	RELATIONSHIP	AGE

MONTHLY INCOME

	PATIENT/RESPONSIBLE PARTY	SPOUSE
GROSS WAGES (before deductions)		
OTHER INCOME:		
INTEREST & DIVIDENDS		
REAL ESTATE RENTAL/LEASE		
SOCIAL SECURITY		
UNEMPLOYMENT/DISABILITY		
ALIMONY/CHILD SUPPORT		
OTHER (attach details)		

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MONTHLY EXPENSES	
RENT/MORTGAGE	
ALIMONY/CHILD SUPPORT	
FOOD/SUPPLIES	
CHILDCARE/SCHOOL	
UTILITIES (Gas, electric, water, phone etc.)	
INSURANCE PREMIUMS (Medical, home, auto)	
AUTO PAYMENTS	
TRANSPORTATION EXPENSES (fuel, repair costs)	
CREDIT CARD/PERSONAL LOAN PAYMENTS	
CURRENT MEDICAL PAYMENTS	
OTHER (provide description)	
OTHER (provide description)	
ASSETS	
CASH ON HAND	
CHECKING ACCOUNT*	
SAVINGS ACCOUNT*	
REAL ESTATE EQUITY	
MOTOR VEHICLE OWNED; YEAR/MAKE/MODEL VALUE	
MOTOR VEHICLE OWNED; YEAR/MAKE/MODEL VALUE	
RV/BOAT/MOTORCYCLE/MOTORHOME YEAR/MAKE/MODEL VALUE	
TRUST ACCOUNTS	
OTHER SOURCES (STOCKS,BONDS)	
*BANK BRANCH(S) & ACCOUNT NUMBERS	

***Please provide two (2) months of the most current bank statements, as well as branch name and account numbers.*

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Eisenhower Medical Center to verify any information listed in this application. We expressly grant permission to contact my/our employer.

Patient Signature _____ **Date** _____

Spouse Signature _____ **Date** _____

Parent/Guardian _____ **Date** _____