Confidential Medical and Financial Assistance Application

Facility:	Acct. #:	Patient Name:	SSN:	DOB:
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

SECTION A

MEDICAL ASSISTANCE SCREENING– *Please check answer "Y" for yes to "N" for no.*

	Y / N
1. Is the patient under age 21 or over age 65?	☐ / ☐
2. Is the patient a single parent of a child under age 21?	☐ / ☐
3. Is the patient a caretaker or guardian of a child under 21?	☐ / ☐
4. Is the patient a married parent of a minor child? *If yes, does the patient have a 30-day incapacitation?*	☐ / ☐
5. Is the patient pregnant, or was the admission pregnancy related?	☐ / ☐
6 Will the patient potentially be disabled for 12 months?	☐ / ☐
7. Is the patient a Victim of Crime?	☐ / ☐
8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed?	☐ / ☐

SECTION B

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:		Relationship to patient:
SSN:	DOB:	
Home Address:		Phone #:
Work Address:		Phone #:
Gross Income: $	Circle One - ☐ Hourly ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	
	Hours Per Week:	
If income is $0/unemployed, what is your means of support?	☐ Living on Savings/Annuity ☐ Live with parent/family/friends ☐ Homeless ☐ Shelter ☐ Deceased ☐ Other: ______	

SPOUSE

Responsibility Party:		
SSN:	DOB:	
Home Address:		Phone #:
Work Address:		Phone #:
Gross Income: $	Circle One - ☐ Hourly ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly	
	Hours Per Week:	

SECTION C

HOMELESS AFFIDAVIT

I, ____, herby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others. Patient/Guarantor Initials______________________

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in the denial of this Application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services maybe considered an unlawful act. I also acknowledge and consent that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Riverside County Regional Medical Center Charity Care program(s) is a "Payor of Last Resort" and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for fitness or injury, for which Riverside County Regional Medical Center or its' subsidiaries provided care.

____ ____________________

PATIENT/GUARANTOR SIGNATURE **DATE**

List **ALL PERSONS LIVING IN THE HOUSE YOU ARE LIVING IN** (**Including yourself**, spouse, significant other & all dependants)

First and Last Name	Social Security Number (**If known**)	Sex	Birth Date	Relationship
1. ____________	____________	M/F	________	____________
2. ____________	____________	M/F	________	____________
3. ____________	____________	M/F	________	____________
4. ____________	____________	M/F	________	____________
5. ____________	____________	M/F	________	____________
6. ____________	____________	M/F	________	____________
7. ____________	____________	M/F	________	____________
8. ____________	____________	M/F	________	____________
9. ____________	____________	M/F	________	____________

Are you, your spouse, significant other or your dependants working? [ ] Yes [ ] No

Person Working	How often do you get paid?	Hours worked a week	Number of days worked a week	Gross income per month
1)				
2)				

Company's Name	**Company's Address**
1)	
2)	

Date you, your spouse/significant other were hired? ____________________

When was the last time you filed income taxes? ____________________

Are you, your spouse, significant other or your dependants self employed? [ ] Yes [ ] No

Person Working	Type of Business	Home Business?	Estimated monthly income after business expenses
1)		Yes [ ] No [ ]	
2)		Yes [ ] No [ ]	

Name of your Business	**Address of your Business**