Central Business Office and Finance Department
P.O. Box 9038
Temecula, CA 92589-9038
(951) 694-3136

SOUTHWEST HEALTHCARE SYSTEM
INLAND VALLEY MEDICAL CENTER
RANCHO SPRINGS MEDICAL CENTER

FINANCIAL STATEMENT SUMMARY

Facility:

Patient Name: Patient Number:

Total Charges: Date of Service: –

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 / Medi-cal
☐ Insurance Coverage
☐ County Program-MISP
☐ Disability
☐ Third Party Liability
☐ Victims of Violent Crimes
☐ Supplemental Security Income
☐ CCS / CDIC
☐ 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

☐ Deceased ☐ Homeless

Manager/Director Approval: _________________________________ Date: __________________________

☐ 88870852

PATIENT OR GUARANTOR MUST SIGN THIS CONFIDENTIAL STATEMENT