The Heart of a Healthy Community
400 NORTH PEPPER AVENUE ▼ COLTON ▼ CALIFORNIA ▼ 92324-1819

FINANCIAL ASSISTANCE PROGRAM

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME ______________________ **SPOUSE** ______________________

ADDRESS ______________________ **PHONE** ______________________

ACCOUNT # ______________________ **SS#** __________ __________
(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support
(If additional space is needed please use page 4)

Name	Age	Relationship
______________________	______	______________
______________________	______	______________
______________________	______	______________
______________________	______	______________

EMPLOYMENT AND OCCUPATION

Employer: ______________________ Position: ______________________

Contact Person and Telephone: ______________________

If self-employed, Name of Business: ______________________

Spouse's Employer: ______________________ Position: ______________________

Contact Person and Telephone: ______________________

If self-employed, Name of Business: ______________________

CURRENT MONTHLY INCOME

	Patient	Spouse
Gross Pay (before deductions)	____________	____________
Section A (Income-Unearned):		
Operating expenses (if self-employed)	____________	____________
Real Estate or Personal Property	____________	____________
Social Security Pension	____________	____________
Retirement or VA benefits	____________	____________
Unemployment	____________	____________
State Disability Insurance (Temporary)	____________	____________
Alimony or Child Support Payments Received	____________	____________
Other (specify):________________________	____________	____________
Total Income:	____________	____________
Section B:		
Alimony, Child Support Payments Paid	____________	____________

Please circle one:

DO YOU HAVE INSURANCE: **YES OR NO**

ARE YOU ELIGIBLE FOR MEDICARE: **YES OR NO**

ARE YOU ELIGIBLE FOR MEDI-CAL: **YES OR NO**

ARE YOU ELIGIBLE FOR GOVERNMENT PROGRAMS? (I.E CRIME VICTIMS, MEDICAL, HEALTHY FAMILIES, OR CALIFORNIA CHILDREN SERVICES, etc)? **YES OR NO**

ARE YOU ELIGIBLE FOR MIA? **YES OR NO**

PLEASE FURNISH THE FOLLOWING INFORMATION

Do you have any Bank Accounts: **YES OR NO,** if yes please complete:

Name of Bank: ____

Account #: ________________ Net Value: ________________

Name of Bank: ____

Account #: ________________ Net Value: ________________

Do you own property other than the home in which you live in: **YES OR NO,** if yes please complete:

Physical Address: ____

City: ____________ State: ______ Zip Code: ________ Net Value: ________________

Do you possess more than one motor vehicle: **YES OR NO,** if yes please complete:

Make: ________________ Model: ________________ Year: ____________

Make: ________________ Model: ________________ Year: ____________

- I declare under penalty or perjury that the answers I have given are true and correct to the best of my knowledge.
- I agree to allow Arrowhead Regional Medical Center to check my employment for the purpose of determining my eligibility for a financial assistance.
- I understand that the information submitted on this application is subject to verification which may include a credit check.
- I understand that I may be required to provide proof of the information I am providing.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the County from the proceeds of any litigation or settlement resulting from such act.

________________________ ________ ________________________ ________
(Signature of Patient or Guarantor) (Date) (Signature of Spouse) (Date)

Additional Space for comments: