



**San Bernardino Mountains Community
Hospital District
Charity Care Application**

INSTRUCTIONS

1. Please complete *all* areas on the attached application form. If any area does not apply to you, write N/A in the space provided.
2. Attach an additional page if you need more space to answer any question.
3. You *must* provide proof of income documents when you submit 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. Signed federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service;

If you did not file a federal income tax return, you must 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.

If you have no income, or proof of income documents, you must provide a letter explaining how you support yourself/family.

4. Your application cannot be processed until *all* required information is provided.
5. It is important that you complete and submit the financial assistance application along with all required attachments within fourteen (14) days.
6. You *must* sign and date the application. If the patient/guarantor and spouse provide information, both *must* sign the application.
7. If you have questions, please call your account representative.
8. Send your completed application to:

San Bernardino Mountains Community Hospital District
Patient Financial Services Department
Attn: Customer Service
PO Box 70
Lake Arrowhead, CA 92352

San Bernardino Mountains Community Hospital District Charity Care Application

PATIENT/ GUARANTOR NAME		SPOUSE NAME	
Address		Home Phone	
		Work Phone	
SOCIAL SECURITY NUMBER			
Patient/ Guarantor		Spouse	

Please list MCH account numbers to be considered for charity care:				

FAMILY STATUS		
List all dependents that you support		
Name	Age	Relationship

EMPLOYMENT STATUS	
Patient/Guarantor Employer	Position

Contact Person	Telephone
Spouse Employer	Position
Contact Person	Telephone

INCOME		
	Patient/Guarantor	Spouse
1. Gross Wages & Salary/Year (before deductions)		
2. Self-Employment Income/Year		
3. Other Income:		
3. Interest & Dividends		
4. Real Estate Rentals & Leases		
5. Social Security		
6. Alimony		
7. Child Support		
8. Unemployment/Disability		
9. Public Assistance		
10. All Other Sources (attach list)		
Total Income (add lines 1 - 10 above)		

UNUSUAL EXPENSES	
Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (attach list as needed).	
Description	Amount

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

Signature of Patient/Guarantor

Signature of Spouse

Date

Date