EL CENTRO REGIONAL MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Instructions

As part of our commitment to serve the community, El Centro Regional Medical Center elects to provide financial assistance to patients/guarantors who are financially indigent or medically indigent and satisfy certain requirements.

To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please provide the following information and copies of information with your financial assistance application:

1. Statement of Financial Condition
2. Documents to verify income

Please provide *one or more* of the following:	**Please provide a copy of the following:**
A. IRS Form W-2, Wage and Earnings Statement for all household earnings; B. Last two pay check stubs for all household earnings; and/or C. Bank statement that contains income information.	A. Governmental Assistance, Social Security or Workers' Compensation, if applicable B. Unemployment compensation letter, if applicable C. Income tax return for previous year (required if patient/guarantor files taxes; if not please provide document from A or B above)

In the event income verification is unavailable, please contact our office for further instructions. Applications without income verification are considered incomplete and will not be processed. For assistance in completing this application, please contact El Centro Regional Medical Center at 760-339-7277, Monday through Friday from 8:00 AM to 5:00 PM. Please return the application and verification of income documents within 14 calendar days to:

Patient Accounting Department-Financial Counseling
El Centro Regional Medical Center
1415 Ross Avenue
El Centro, California 92243

Please note that physicians providing services at El Centro Regional Medical Center are not employees of El Centro Regional Medical Center. You will receive separate bills from your private physician and from other physicians whose services you required (e.g. surgeon, radiologist, anesthesiologist, pathologist, hospitalist, etc.). The Financial Assistance Application does not apply to any amounts due by you for physician services. For questions regarding their bills, or to make payment arrangements for physician services, please contact the individual physician's office. We will notify you of your eligibility following receipt and review of all necessary information. The notification will be mailed to the mailing address you have provided on the Financial Assistance Application.

EL CENTRO REGIONAL MEDICAL CENTER
STATEMENT OF FINANCIAL CONDITION

PATIENT NAME/SSN: _____ ACCOUNT NO._____
GUARANTOR NAME/SSN: _____
GUARANTOR NAME/SSN: _____
ADDRESS: _____
_____
PHONE: _____

FAMILY STATUS: List all dependents in the household

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT AND OCCUPATION

Employer:_____ Position:_____
Contact Person and Telephone: _____
If Self-Employed, Name of Business: _____

Spouse Employer:_____ Position:_____
Contact Person and Telephone: _____
If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

		Guarantor	Guarantor
	Gross Pay (before deductions)	_____	_____
Add	Income from Operating Business (if Self-employed)	_____	_____
Add	Other Income:		
	Interest and Dividends	_____	_____
	From Real Estate or Personal Property	_____	_____
	Social Security	_____	_____
	Other (specify):	_____	_____
	Alimony or Support Payments Received	_____	_____
Subtract	Alimony, Support Payments Paid	_____	_____
Equals	Current Monthly Income	_____	_____
	Total Monthly Income (combine both Guarantors)	_____	

FAMILY SIZE

Total Family Members _____

(Add patient, guarantors and dependents from above)

By signing this form, I agree to allow El Centro Regional Medical Center to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I am also required to provide the documents outlined in the ECRMC Financial Assistance Application Instructions within 14 days.

_____ _____

Signature of Guarantor Date

_____ _____

Signature of Guarantor Date