Community Hospital of San Bernardino
A Dignity Health Member

Payment Assistance Application

Patient Account Number

Patient Last Name | Patient First Name | Patient Social Security # | Patient Date of Birth

Guarantor Last Name (If Different) | First Name | Guarantor Social Security # | Date of Birth

Guarantor Home Address | ( ) Home Telephone Number

City | State | Zip Code

Guarantor's Employer Name | $ Guarantor's Annual Income | Guarantor Job Function/Department

Guarantor's Employer Address | ( ) Guarantor's Employer Telephone

City | State | Zip Code

Spouse's Employer Name | $ Spouses Annual Income | Spouse's Job Function/Department

Spouse's Employer Address | ( ) Spouse's Employer Telephone

City | State | Zip Code

People In Household

Name	Relationship to Patient	Date of Birth	Employer	Employer Telephone
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				

Dignity Health Payment Assistance Application (Continued)

Please complete the table below as completely as possible:

Income Analysis		Qualified Monetary Asset Analysis	
In order to determine your eligibility for the Dignity Health Payment Assistance Program please provide us with information about your annual before-tax household income.		*Please* ***do not*** *include any funds held in tax exempt/deferred accounts such as 401K savings accounts, 403B savings accounts, and IRA savings accounts.*	
Job Income	$	Checking Account(s)	$
Spouse Job Income	$	Savings Account(s)	$
Business Income	$	Stocks, Bonds & CDs	$
Rental Income	$	Other: _____	$
Interest/Dividend Income	$	Other: _____	$
Social Security Income	$	Other: _____	$
Alimony or Support Payments	$	Other: _____	$
Other Income	$	Other: _____	$
Total Income	**$**	**Total Qualified Monetary Assets**	**$**

In order to determine who truly needs financial assistance, we must require the submission of information to demonstrate financial hardship. Please complete the attached application and return it with all of the following items. If you are unable to supply one of the documents or there are additional factors that may influence the evaluation, please submit a written statement explaining your situation.

1) **Proof of Identity** - One of the following:
   - Copy of Social Security Card
   - Copy of state issued driver's license
   - Copy of other photo ID

2) **Proof of Monetary Assets** - All of the following (if applicable):
   - Last three months checking *and* savings account statements
   - Documentation about stocks, bonds, and/or CDs

3) **Verification of Current Address** - One of the following:
   - Rent receipt or Utility Bill

4) **A copy of a state Medicaid/Medi-Cal/AHCCCS decision/denial notice (if applicable)**

5) **Proof of Income:**
   - If employed, include a copy of prior year tax return *and* W-2 (earnings statement provided by your employer) *and* check stubs from the most recent prior three months.
   - If receiving public assistance, include copies of public assistance checks from each of the prior three months *or* award letter (i.e. disability, unemployment pay stubs, or social security benefits.)
   - If employment income is received in cash, include a written statement from your employer stating your monthly income for the last three months.
   - If self-employed, include Schedule C of prior year tax return *and* a quarterly accountant report with a written statement declaring gross income received during the last three months.
   - If not receiving a consistent income, write a brief paragraph on a separate paper stating your financial situation over the last three months. Explain how or from what source you are receiving monies to pay for your basic living expenses such as food and housing.
   - If dependent upon another individual's financial support, include a "letter of financial support."

By signing below you agree to be considered for Payment Assistance. Additionally, you certify that all the statements made on this application are true and complete to the best of your knowledge. Should it be determined that the information you provided is incomplete or false, any discount on your bill may be reversed and payment in full may be expected from you. By signing below, you authorize Dignity Health to check references and credit history in order to evaluate this application for financial assistance consideration.

If you receive payment from an insurance company, workers' compensation plan, or any other third party, you agree to inform the hospital of any such payment. The hospital retains its right to collect the original, full billed charges should a third party provide you with payment for the hospital's services.

Signature of Person Responsible For Bill (Guarantor) _____ Date _____