EISENHOWER MEDICAL CENTER

Financial Assistance Application Instructions

If you do not have insurance coverage, or are underinsured, you may be eligible for charity care or other hospital discount. Any individual whose family income is at or below 400% of the Federal Poverty Level may be eligible for discounted services under the hospital's charity care policy. In addition, patients without insurance coverage may be eligible for government programs such as Medi-Cal, County Indigent and other government funded healthcare assistance programs. You are also welcome to obtain applications for coverage offered through the California Health Benefit Exchange: www.coveredca.com, or through the Riverside Department of Public Social Services at (800) 274-2050 or www.rivcodpss.org, or by contacting Health Consumer Alliance at www.healthconsumer.org.

Please indicate if you are applying for Charity Care or Discount Payment by checking the appropriate box below.

☐ Charity Care – If approved, this can provide up to a full write-off of all patient balances included in the approved time period.

☐ Discount Payment – If approved, this can provide a reduced payment of up to 70% of all patient balances included in the approved time period.

1. Please complete ***all*** areas on the attached application form. If any area does not apply to you, please write N/A (not applicable) in the space provided.

2. Attach an additional page if you need more space to answer a question.

3. You ***must*** provide proof of income when submitting this application. One of the following documents must be attached:

   a. Federal Income Tax Return (for example form 1040) for the year in which the patient was first billed for 12 months prior to when the patient was first billed, including all schedules and attachments, as submitted to the Internal Revenue Service (IRS).

   OR

   b. Six (6) months of paycheck stubs or social security, disability, or unemployment benefit statements from within a 6-month period before or after the patient was first billed by the hospital, or in the case of preservice, when the application is submitted.

4. A letter explaining your current situation and why payment arrangements cannot be made, and a letter from the person providing support if no income is received.

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5. Your application cannot be processed until ***all*** required information is provided. It is important that you complete and submit the financial assistance application along with all required documentation **as soon as possible**.

6. You ***must*** sign and date the applications. If the patient/guarantor and spouse provide information, both must sign the application.

7. If you have questions, please contact a Patient Financial Services Representative at (760) 837-8376.

8. Send your completed application to:
   Eisenhower Medical Center
   Attn: Patient Financial Services Department – Financial Assistance
   39000 Bob Hope Drive
   Rancho Mirage, CA 92270
   Fax (760) 773-4317

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PATIENT FINANCIAL ASSISTANCE APPLICATION

ACCOUNT/MEDICAL RECORD #:_____

RESPONSIBLE PARTY NAME: LAST FIRST MIDDLE	
PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY:	SOCIAL SECURITY #:
ADDRESS:	PHONE:
CITY, STATE & ZIP:	WORK/CELL PHONE:
EMPLOYER: CONTACT PERSON/PHONE #	OCCUPATION:

SPOUSE INFORMATION	
NAME: LAST FIRST M.I.	SOCIAL SECURITY #:
ADDRESS:	PHONE:
CITY, STATE & ZIP:	WORK/CELL PHONE:
EMPLOYER: CONTACT PERSON/PHONE #:	OCCUPATION:

LIST ALL DEPENDENTS		
NAME	RELATIONSHIP	AGE

MONTHLY INCOME		
	PATIENT/RESPONSIBLE PARTY	**SPOUSE**
GROSS WAGES (before deductions)		
OTHER INCOME:		

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REAL ESTATE RENTAL/LEASE		
SOCIAL SECURITY		
UNEMPLOYMENT/DISABILITY		
ALIMONY/CHILD SUPPORT		
OTHER (attach details)		
MONTHLY EXPENSES		
RENT/MORTGAGE		
ALIMONY/CHILD SUPPORT		
FOOD/SUPPLIES		
CHILDCARE/SCHOOL		
UTILITIES (Gas, electric, water, phone etc.)		
INSURANCE PREMIUMS (Medical, home, auto)		
AUTO PAYMENTS		
TRANSPORTATION EXPENSES (fuel, repair costs)		
CREDIT CARD/PERSONAL LOAN PAYMENTS		
CURRENT MEDICAL PAYMENTS		
OTHER EXPENSES (provide description)		
OTHER EXPENSES (provide 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 Eisenhower Medical Center to verify any information listed in this application. We expressly grant permission to contact my/our employer.

Patient Signature _____ **Date** _____

Spouse Signature _____ **Date** _____

Parent/Guardian _____ **Date** _____