



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 rivcodpss.org, or by contacting Health Consumer Alliance at 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. Prior year's Federal Income Tax Return (ex. form 1040) and should include all schedules and attachments, as submitted to the Internal Revenue Service (IRS).

OR

- b. Six (6) months of most recent paycheck stubs or social security, disability, or unemployment benefit statements.
4. Letter explaining your current situation and why payment arrangements cannot be made. A letter from the person providing support if no income is received.
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**.



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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: | | |
| REAL ESTATE RENTAL/LEASE | | |
| SOCIAL SECURITY | | |



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| | | |
|--|--|--|
| 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 (provide description) | | |
| OTHER (provide description) | | |

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 _____