ARROWHEAD REGIONAL MEDICAL CENTER
Administration Policies and Procedures

SECTION: **ADMINISTRATIVE**

SUB SECTION: **OPERATIONS**

SUBJECT: **PATIENT FINANCIAL ASSISTANCE**

APPROVED BY: ____________________
Chief Executive Officer

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PURPOSE

The purpose of this policy is to define the eligibility criteria for Financial Assistance and to provide guidelines for the identification and classification of patient outstanding balances.

POLICY

Arrowhead Regional Medical Center (ARMC) is committed to providing quality healthcare to the community and helping persons who have healthcare needs and are uninsured, underinsured, ineligible for government programs, the California Health Benefit Exchange and are otherwise unable to pay for medically necessary care based on their individual financial situations. ARMC strives to ensure that the financial capacity of those who need health care services does not prevent them from seeking or receiving care. Patients are expected to comply with ARMC's procedures for obtaining Financial Assistance and to contribute to the cost of their care based on their individual ability to pay.

Emergency Physicians, (as defined in Health and Safety Code Section 127450), who provide emergency medical services in a hospital that provides emergency care, are also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital.

DEFINITIONS

I. **Financial Assistance**: That portion of patient care services provided by Arrowhead Regional Medical Center for which a patient does not have the ability to pay. Financial Assistance may include unpaid coinsurance, copayments, deductibles, and non-covered services if the patient meets the hospital's eligibility criteria.

II. **High Medical Costs**: An insured patient with "High Medical Costs" means:

A. A person whose family income does not exceed 550% of the federal poverty level if the individual does not receive a discounted rate from the hospital, or any of the following:
1. Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10% of the patient's current family income or family income in the prior 12 months, whichever is less.
2. Annual out-of-pocket expenses that exceed 10% of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or patient's family in the prior 12 months.

3. A lower level determined by the hospital in accordance with the hospital's charge policies.

III. **Income:** The sum of all wages, salaries, rent and other forms of earnings received by the patient's family. This includes profit and loss statements for the last three months OR a current tax return for self-employed patients.

A. In some instances, the net income may be used instead of gross income to determine Financial Assistance eligibility.

IV. **Local Consumer Center:** An agency designed to provide consumers with information about healthcare coverage and services. In California, The Health Consumer Alliance (HCA) was designated as the CCI/Cal Mediconnect Ombuds Program effective April 1, 2014. More information regarding HCA can be found at http://healthconsumer.org. Consumers may call 888-804-3536 for routing to the correct consumer center.

TYPE OF SERVICES COVERED

All services rendered by Arrowhead Regional Medical Center are eligible for Financial Assistance. This does not include professional services.

PROCEDURES

I. ELIGIBILITY

A. Eligibility for Financial Assistance will be considered for those individuals, who are uninsured, underinsured, ineligible for any government health care benefit program, the California Health Benefit Exchange and unable to pay for their care, based upon a determination of financial need. *The granting of Financial Assistance shall not consider age, gender, race, social or immigrant status, sexual orientation, or religious affiliation.* Patients who are denied eligibility to government programs for failing to cooperate with the eligibility process will not be eligible for Financial Assistance. Patients who provide written or verbal attestations of income (Section I.F), or patients subject to presumptive eligibility (Section III), may be eligible at the discretion of the Chief Financial Officer (CFO).
1. If the Patient is eligible for Financial Assistance through the outlined screening process below, they will be eligible for Financial Assistance for one year from the date of approval.
2. Additional applications for subsequent medical visits will not be required during the one-year eligibility period.

B. The primary eligibility categories are:
1. Charity:
a. Patient is uninsured AND patient's family income is at or less than 400% of the Federal Poverty Level (FPL) designated for the patient's family size.
b. Patient is insured AND patient's family income is at or less than 400% of the Federal Poverty Level (FPL) designated for the patient's family size AND the patient meets the definition of a "High-Cost Medical" patient above.
2. Financial Assistance:
a. Patient is uninsured AND patient's family income ranges between 401% and 550% of the Federal Poverty Level (FPL) designated for the patient's family size.

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b. Patient is insured AND patient's family income ranges between 401% and 550% of the Federal Poverty Level (FPL) designated for the patient's family size AND the patient meets the definition of a "High-Cost Medical" patient above.

C. Per SB 1276 – Hospital Fair Billing Policies regulation, Financial Assistance may extend to those persons who receive a discounted rate from the hospital as a result of 3rd party coverage, effective January 1, 2015.

D. In determining eligibility under Financial Assistance, the hospital may consider income and monetary assets of the patient. For purposes of determination, monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code and/or or nonqualified deferred compensation plans. Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility. (Health & Safety Code Section 127405)

E. Medicare Deductible and Co-Insurance:
1. Patients whose primary coverage is Medicare may qualify for Charity Care under certain circumstances. The amount qualifying for full charity is limited to the Medicare coinsurance and deductible amounts **unreimbursed** by any other payer including Medi-Cal/Medicaid, and which is not reimbursed by Medicare as a bad debt, if:
a. The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or
b. The patient otherwise qualifies for Financial Assistance under this policy and then only to the extent of the write-off provided for under this policy.
c. Medicare applicants will need to submit a complete Financial Assistance application to be considered for assistance under this policy.
1) Section III. Process for Presumptive Eligibility does not apply to the Medicare population for this reason.

F. When the patient is unable to provide documentation verifying income, the following procedures shall be followed:
1. Written Attestation: Patient can sign a statement attesting to the accuracy of the income information provided.
2. Verbal Attestation: The Hospital financial counselor may provide written attestation that the patient verbally verified the income calculation. Some attempts should be made to document the patient's yearly income before taking a verbal attestation.

G. Special circumstance discounts may be offered on a case-by-case basis if FPL is over 550%. Please refer to Patient Accounts Policy No. 805.01 for more information.

II. Determination of Financial Need

A. Financial need shall be determined by an assessment of the Applicants financial situation, which will include an application process that the patient or the patient's guarantor is required to complete. The patient or his/her guarantor is expected to supply all documentation necessary to make the determination of financial need. Failure to provide necessary verification within thirty (30) calendar days of request shall result in denial of application. However, financial assistance may be provided to patients with no

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documentation that are subject to presumptive eligibility (as stated in Section III). Necessary documentation shall include:

1. Copy of Picture Identification
2. Proof of Income
3. Proof of Spouses Income (if married)
4. Statement of Support providing explanation if living with no Income

B. ARMC's staff shall make a reasonable effort to assist patients in applying for alternative sources of assistance through the California Health Benefit Exchange or other state- or county-funded health coverage programs.

C. Any patient who applies, or has a pending application, for another health coverage program at the same time he or she applies for Financial Assistance, neither application precludes eligibility for the other program.

D. Any patient who indicates the financial inability to pay a bill for medically necessary service shall be evaluated for Financial Assistance. ARMC shall also provide the patient with a referral or list of local consumer assistance centers that are housed at legal services offices.

III. Determination Process for Presumptive Eligibility

A. There may be instances where a patient may appear eligible for Financial Assistance discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, ARMC could use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the discount applied will be based on the eligibility guidelines listed above. Presumptive eligibility may be determined based on individual life circumstances that may include:

1. Homeless or received care from a homeless clinic
2. Patient is deceased without an estate or third-party coverage
3. Medi-Cal/Medicaid Denials – patients who do not qualify for Medi-Cal/Medicaid are also:
   a. Presumed to qualify for full charity care
   b. This includes patients whose Medi-Cal/Medicaid coverage is non-covered, limited, or restricted. This may include Share of Cost (SOC) amounts if deemed appropriate.
4. Special circumstance discounts may be offered on a case-by-case basis, please refer to Patient Accounts Policy No. 805.01 for more information.

IV. Financial Assistance Application

A. ARMC's Determination of Benefit Eligibility form and Screening form shall be used to document each patient's financial situation (Attachment B). The patient will be sent a notification form once a final eligibility determination is made.

V. Considerations

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A. Family income will be considered when evaluating eligibility for Financial Assistance as well as potential payments from pending litigation and third-party liens related to the incident of care.

B. The amount and frequency of hospital bills may also be considered.

C. A patient's eligibility for Financial Assistance may be determined any time information on the patient's eligibility becomes available.

D. For services provided to patients with income that ranges between 401% and 550% of the FPL, the patient will be responsible for the remaining balance after the application of the allowable discounted rate as determined pursuant to Financial Assistance Guidelines below.

VI. Financial Assistance Guidelines

A. Financial Assistance shall be made in accordance with the patient's financial need as determined by the Federal Poverty Level (FPL) in effect at the time of financial determination.

1. Charity: Patients with an income ranging at or less than 400% of the FPL shall receive a discount equal to the current outstanding balance on the account(s).
2. Financial Assistance: Patients with an income ranging between 401% and 550% of the FPL are eligible to receive discounted services and may receive those services at a rate not to exceed the Medicare reimbursement rate. If the inpatient Medicare rate exceeds the billed charges, the billing will be discounted by applying the Medicare outpatient percentage.
3. Upon determination that the patient does not qualify for Medi-Cal, the application shall be reviewed for eligibility for Charity/Financial Assistance.

VII. Communication of the Financial Assistance Program

A. Arrowhead Regional Medical Center shall make every effort to ensure all patients receive Financial Assistance information. The "Patient Financial Services Information" notice shall be distributed to patients upon admission and as part of the outpatient consent package. Information shall also be posted in each patient registration lobby throughout the facility.

B. Hospital bills sent to uninsured patients will include:

1. A detailed statement of charges for services rendered.
2. A request that the patient inform the hospital if the patient has health insurance coverage or coverage under a government health program.
3. A statement that provides the patient with a hospital contact resource from which the patient may obtain information about the hospital's Financial Assistance Policy for low-income uninsured patients and how to apply for such assistance for the payment of services that were provided.

C. ARMC shall provide, at the patient's request, a copy of the Financial Assistance policy.

D. ARMC shall prominently display a notice of the hospital's financial assistance policy for patients on its website.

VIII. Patient Redetermination/Appeal Process

A. Any patient denied eligibility for Financial Assistance may request a re-evaluation if they can attest that their financial situation has changed significantly and/or file an appeal if

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they do not agree with the initial application decision. All requests are to be submitted to the Patient Accounts Department, 400 N Pepper Ave., Colton, CA 92324. The patient shall be notified in writing of the outcome within forty-five (45) days.

B. If the patient was previously approved for a service discount due to FPL guidelines but then becomes eligible to receive services free of charge due to the appeal process, ARMC is authorized to go back to adjust previous balances otherwise approved under the discount agreement due to appeal being overturned (this is a result in a change in financial circumstances), or based Section III, A.

IX. Advancing Debt for Collection

A. Amounts determined to be patient liability may be assigned to a collection agency pursuant to the Patient Notification of Debt Collection Referral Policy located in the Patient Accounts Policy & Procedure Manual.

B. ARMC shall provide a copy of its Debt Collection Referral Policy to California Department of Public Health Care Access and Information.

X. Collections

A. ARMC will not knowingly send patient bills to Central Collections prior to 180 days from time of initial billing for those patients that lack coverage or have high medical costs. Income and asset information obtained for the purpose of determining eligibility for financial Assistance shall not be used for the purpose of collections.

B. ARMC will not knowingly send patient bills to Central Collections unless specified conditions are met, including that the patient is ineligible for financial assistance and that the patient hasn't responded to billing attempts or financial assistance offerings.

C. Before assigning a patient bill to Central Collections, ARMC will be required to send a notice to the patient that includes the date or services of the bill, the name of the entity the bill is being assigned to, a statement that shows how to obtain an itemized bill and an application for the hospital's financial assistance program.

D. ARMC shall provide Central Collections with a copy of the Patient Financial Assistance Policy, along with ARMC's Mission Statement. As part of its processing of patient accounts for ARMC, Central Collections shall agree to adhere to the Financial Assistance Policy. Central Collections shall also comply with all State and Federal laws regarding collection practices. Central Collections shall not use wage garnishments or seek liens against the primary residence of any patient qualified through the Financial Assistance program.

E. All collection efforts will be suspended while a guarantor is actively participating in the Financial Assistance application process.

XI. Repayment

A. ARMC and Central Collections shall work with patients qualified through Financial Assistance to negotiate a monthly repayment agreement for any balances due based on the patient's ability to pay. Such a plan shall be free of interest. If ARMC and the patient cannot agree on a repayment plan, ARMC shall institute a reasonable payment plan, with monthly payments of less than 10 percent of a patient's family income for a month after

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deductions for essential living expenses. Payment plans may be deemed inoperable should the patient fail to make all scheduled payments. ARMC or Central Collections shall make reasonable effort to contact the patient to renegotiate a new agreement before a repayment plan is deemed inoperable. Contact efforts shall include an attempt to telephone the patient at the last known phone number, and written notice sent to the last known address. No civil action or adverse credit reporting shall take place until such time that all contact attempts have been made and the extended repayment plan is declared to be no longer operative.

XII. Overpayments

A. An account shall be considered overpaid only when payment is received directly from the patient, spouse, or parent of a minor after the date that Financial Assistance application has been processed and approved. Payments will not be returned for any prior payments on accounts before the Financial Assistance application is processed. Payment from any third-party source shall not constitute an overpayment unless such payment is in excess of billed charges. If an overpayment is identified, ARMC or Central Collections shall reimburse patients the amount overpaid plus interest at the legal rate established in Code of Civil Procedure Section 685.010. Reimbursement or interest shall not be required if the amount due is less than $5.00.

XIII. Education and Training

A. Hospital Staff shall receive training regarding the Financial Assistance. The following staff shall be trained:
1. Registration/Admitting
2. Financial Interviewers
3. Patient Advocate
4. Billing/Patient Accounts

XIV. Regulatory Requirements

A. In implementing this policy, Arrowhead Regional Medical Center shall comply with all federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.

XV. Non-Covered Services

A. In accordance with requirement §1.501(r)-4(b)(1)(iii)(F) of the Treasury Regulations, Arrowhead Regional Medical Center must identify any providers, other than the hospital facility itself, delivering emergency or other medically necessary care in the hospital facility who are not covered under ARMC's Financial Assistance Policy. A patient will be financially responsible for any services provided by the listed providers and Arrowhead Regional Medical Center will not be held responsible.

B. The Patient Accounts Department will maintain a list of non-covered providers (Attachment C) in a document separate from the Financial Assistance Policy and the document must include the date on which it was created or last updated. The non-covered provider list must be updated on a quarterly basis to ensure that the list is accurate and up-to-date, and it must be made readily available to the public, both online and on paper.

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C. If the only change Arrowhead Regional Medical Center makes to its Financial Assistance policy is to update the provider list, the FAP Policy does not need to be adopted by an authorized body for the policy to continue to be established.

XVI. Declaration of Local Health Emergency Procedures

A. A local health emergency must be proclaimed by the County's Public Health Officer and/or the Board of Supervisors and attached to this patient financial assistance document as an addendum (Attachment A).

1. A healthcare emergency may be related to an emergent situation whereby state / federal regulations are modified to meet the immediate healthcare needs of the hospital's community during a healthcare crisis.

B. During a healthcare emergency, Arrowhead Regional Medical Center may "flex" its Financial Assistance policy to meet the needs of the community in crisis. These changes will be included in the patient financial assistance policy as included as an addendum.

C. Patient discounts related to medical treatment may be provided at the time of the crisis, regardless of the date of this policy (as hospital leadership may not be able to react quickly enough to update policy language to meet more pressing needs during the healthcare emergency).

REFERENCES: **California Health & Safety Code Sections 127400-127455**
AB 103. Stats. 2010, Ch. 445 Section 127450
SB 1276. Stats. 2014, Ch. 758
Administrative (ADM) Policy #100.03
Treasury Regulations §1.501(r)-4(b)(1)(iii)(F)
Administrative Policy No. 100.03, Policy and Procedure Manuals-Format, Standards and Approval Process

DEFINITIONS: **N/A**

ATTACHMENTS: **Attachment A: Declaration of a Local Health Emergency**
Attachment B: Application – English & Spanish
Attachment C: Non-Covered Provider List

APPROVAL DATE:

Date	Committee
N/A	**Policy, Procedure and Standards Committee**
11/23/2022	**Patient Safety and Quality Committee** Applicable Administrator, Hospital or Medical Committee
12/8/2022	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
1/26/2023	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee

REPLACES: **Administrative Policy No. 110.28**
Administrative Policy No. 110.29 Issue 9

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EFFECTIVE: **2/5/2007**

REVISED: **8/13/2010, 1/3/2012, 1/2/2014, 1/1/2015, 8/20/2015, 7/1/2016, 1/1/2020, 10/4/2021**

REVIEWED: 9/12/2022

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351 N. Mountain View Ave., San Bernardino, CA 92415 | Phone: 909.387.9146 Fax: 909.387.6228
www.SBCounty.gov

Public Health
Administration

Trudy Raymundo
Director

Corwin Porter
Assistant Director

Maxwell Ohikhuare, M.D.
Health Officer

DECLARATION OF A LOCAL HEALTH EMERGENCY

WHEREAS, Health and *Safety* Code section 101080 authorizes a local Health Officer to declare a local health emergency in the health officer's jurisdiction, or any part thereof, whenever the Health Officer reasonably determines that there is an imminent and proximate threat of the introduction of any contagious, infectious, or communicable disease, chemical agent, non-communicable biologic agent, toxin, or radioactive agent;

WHEREAS, community spread of COVID-19 is occurring in the United States;

WHEREAS, based on community transmission of COVID-19 in the United States, including in neighboring counties, there is an ongoing risk and likelihood of COVID-19 positive patients being identified in San Bernardino County;

WHEREAS, based on the foregoing, there is an imminent and proximate threat of the introduction of COVID-19 in the County of San Bernardino and a threat to the public health of the County residents;

THEREFORE, the County Health Officer hereby declares a health emergency.

Erin Gustafson, M.D., MPH
Acting Health Officer

Date

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400 N. Pepper Avenue, Colton, California 92324-1819 | Phone: 909.580.1000
www.arrowheadmedcenter.org

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ARMC
400 N PEPPER AVE
COLTON CA 92324
1-877-818-0672
ATTN: PATIENT ACCOUNTS DEPARTMENT

In order to make your application complete, the following documentation must be included:

- **PROOF OF DENIAL FROM MEDI-CAL (if applicable)**
- **COPY OF PICTURE IDENTIFICATION**
- **PROOF OF INCOME**
- **PROOF OF SPOUSES INCOME (if applicable)**
- **STATEMENT OF SUPPORT IF THERE IS NO INCOME**

Failure to submit all required documentation with the application will result in an incomplete application.

The application process takes approximately 45 days from the date the application is received.

FAILURE TO COMPLY WITH THE QUALIFICATION REQUIREMENTS FOR ANY GOVERNMENT ASSISTANCE PROGRAM WILL RESULT IN FINANCIAL ASSISTANCE DENIAL.

Please be advised that this application is for Arrowhead Regional Medical Center (ARMC) Charges only and coverage does not apply to the Professional Fees incurred, such as Physicians, Anesthesiologist, Radiology, Laboratory, etc. THESE CHARGES WILL BE YOUR FINANCIAL RESPONSIBILITY.

Arrowhead Regional Medical Center maintains a list of non-covered providers you can find it online at https://www.arrowheadmedcenter.org or you may request a copy by calling Patient Accounts department 1-877-818-0672.

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FINANCIAL ASSISTANCE PROGRAM
STATEMENT OF FINANCIAL CONDITION

PATIENT NAME ______________________________ SPOUSE ____________________

ADDRESS ____________________________________ PHONE ____________________

CITY ____________________________ STATE ________ ZIP CODE ______________

MR# or V# ____________________ SS# ____________________ SS# ____________________
(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support
(If additional space is needed please use page 5)

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION

Employer: ____________________________________ Position: __________________

Contact Person and Telephone: ____

If self-employed, Name of Business: ____

Spouse's Employer: ______________________________ Position: __________________

Contact Person and Telephone: ____

If self-employed, Name of Business: ____

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CURRENT MONTHLY INCOME

	Patient	Spouse
Gross Pay (before deductions)	______________	______________
Section A (Income-Unearned):		
Social Security Pension	______________	______________
Retirement or VA benefits	______________	______________
Unemployment	______________	______________
State Disability Insurance (Temporary)	______________	______________
Alimony or Child Support Payments Received	______________	______________
Other (specify) ____________________	______________	______________
Total Income:	______________	______________
Section B:		
Alimony, Child Support Payments Paid	______________	______________

Please circle one:

Do you have Insurance: **YES OR NO**
Are you eligible for MEDICARE: **YES OR NO**
Are you Eligible for MEDI-CAL: **YES OR NO**
Are you eligible for government programs: (i.e. Victims of Crime, Medi-Cal, Healthy Families, or California Children Services (CCS), etc.) **YES OR NO**

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PLEASE AGREE TO THE FOLLOWING INFORMATION

- **I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.**
- **I agree to allow Arrowhead Regional Medical Center to check my employment for the purpose of determining my eligibility for a financial assistance.**
- **I understand that the information submitted on this application is subject to verification which may include a credit check.**
- **I understand that I may be required to provide proof of the information I am providing.**
- **I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the County from the proceeds of any litigation or settlement resulting from such act.**

______________________________ ___________ ______________________________ ___________
(Signature of Patient or Guarantor) (Date) (Signature of Spouse) (Date)

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Additional Space for comments:

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ARMC
400 N PEPPER AVE
COLTON CA 92324
1-877-818-0672
ATTN. PATIENT ACCOUNTS DEPARTMENT

A fin de completar esta solicitud, la siguiente documentación debe ser incluida:

- **COPIA DE DESAPROBACIÓN DEL PROGRAMA MEDI-CAL (si corresponde)**
- **COPIA DE IDENTIFICACIÓN CON FOTO**
- **PRUEBA DE INGRESOS**
- **PRUEBA DE INGRESOS DE SU ESPOSO (A) (si corresponde)**
- **CARTA DE SOSTENIMIENTO (STATEMENT OF SUPPORT) Si no tiene ingresos**

El no presentar toda la documentación necesaria con la solicitud resultara en una solicitud incompleta.

El proceso de solicitud toma aproximadamente 45 dias a partir de la fecha de recibida la solicitud.

INCUMPLIMIENTO DE LOS REQUISITOS DE CALIFICACIÓN PARA CUALQUIER PROGRAMA DE ASISTENCIA DEL GOBIERNO DARÁ LUGAR A LA DESAPROBACIÓN DEL PROGRAMA DE ASISTENCIA FINANCIERA.

Se le Avisa que el Programa de Asistencia Financiera cubre Solamente los Cargos del Hospital Arrowhead Regional Medical Center (ARMC) y No Cubre los Cargos Incurridos por Profesionales, tales como Doctores, Anestesiólogo, Radiología, Laboratorio etc. LOS CARGOS PROFESIONALES SERÁN SU RESPONSABILIDAD FINANCIERA.

El hospital Arrowhead Regional Medical Center mantiene una lista de los proveedores que no son cubiertos por el programa de Asistencia Financiera la cual puede encontrar en nuestro sitio web https://www.arrowheadmedcenter.org o puede pedir una copia llamando al departamento de Cuentas del Paciente (Patient Accounts) 1-877-818-0672.

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PROGRAMA DE ASISTENCIA FINANCIERA
DECLARACIÓN DE SITUACIÓN FINANCIERA

NOMBRE DE PACIENTE: ___________________________ **ESPOSO (A):**____________________

DOMICILLO: ____ **TELEFONO:** ________________

CIUDAD: ____________________________ **ESTADO** _________ **CODIGO POSTAL:** ___________

MR# o V# ___________________________ **SS#** __________________ **SS#** ____________________
(Paciente) **(Esposo (a)**

ESTADO DE FAMILIA: Lista de todos los dependientes que usted mantiene
(Si necesita espacio adicional favor de utilizar la página 5)

Nombre	Edad	Relación

EMPLEO Y OCUPACIÓN

Empresa: ____ **Ocupación:** ______________________
Nombre y teléfono de supervisor: ____
Si tiene negocio propio, nombre del negocio: ____
Empresa de esposo (a): ___________________________________ **Ocupación:** ________________
Nombre y teléfono de supervisor de su esposo (a): ____
Si tiene negocio propio, nombre del negocio: ____

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INGRESOS MENSUALES

	Paciente	Esposo (a)
Sueldo en bruto (antes de deducción)	____________	____________
Sección A (Ingresos-no consumado):		
Pensión de Seguro Social	____________	____________
Pensión de Veteranos	____________	____________
Beneficios de Desempleo	____________	____________
Seguro Estatal por Incapacidad (Temporal)	____________	____________
Pensión alimenticia (hijos) (Child Support)	____________	____________
Pensión alimenticia (esposo (a) (Alimony)	____________	____________
Otro (especificar):	____________	____________
TOTAL:	____________	____________

Sección B:

¿Paga usted pensión alimenticia a esposo (a) o pensión alimenticia a (hijos) por motivo de una orden judicial o por algún acuerdo con el Procurador de Distrito? ________________________

Tiene seguro médico: **SÍ O NO**

Es usted elegible para seguro de MEDICARE: **SÍ O NO**

Es usted elegible para seguro de MEDI-CAL: **SÍ O NO**

Es usted elegible para (Victimas de Crimen, Medi-Cal, Healthy Families, o California Children Services (CCS), etc.) **SÍ O NO**

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www.arrowheadmedcenter.org

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FAVOR DE FIRMAR EN ACUERDO CON LA SIGUIENTE INFORMACION

- **Declaro bajo perjurio que las respuestas que he proporcionado son verdaderas y correctas de acuerdo a lo que se.**
- **Estoy de acuerdo en permitirle a Arrowhead Regional Medical Center verificar mi lugar de empleo.**
- **Entiendo que la información sometida puede ser sujeto a verificación lo cual puede incluir una verificación de crédito.**
- **Entiendo que puedo ser requerido a proporcionar la prueba de la información que estoy proporcionando.**
- **Además estoy de acuerdo, que en consideración por recibir servicios de atención médica como consecuencia de un accidente o lesión, debo rembolsar al Condado de las ganancias de cualquier litigio o la liquidación resultante de dicha ley.**

______________________________	__________	______________________________	__________
(Firma de Paciente o Garantizador)	**(Fecha)**	**(Firma de Esposo (a)**	**(Fecha)**

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ARROWHEAD REGIONAL MEDICAL CENTER
HOSPITAL PROVIDER LIST

Physician Group	Services Provided	Contact Information
Arrowhead Family Medical Group Inc.	Family Medicine Services	Arrowhead Family Medical Group Inc. PO Box 8714, Redlands, CA 92375 (909) 580-3370
Arrowhead Pathology Medical Group	Pathology Services	Arrowhead Pathology Medical Group 400 N Pepper Ave., Colton, CA 92324 (909) 580-0010
Arrowhead Pediatric Medical Group	Pediatric Services	Arrowhead Pediatric Medical Group 400 N Pepper Ave., Colton, CA 92324 (909) 580-6315
CEP America (Vituity)	Psychiatric Services	CEP America (Vituity) 430 N Vineyard Ave., Ontario, CA 91764 Patient Inquiries: 1-800-498-7157 Spanish Inquiries: 1-800-952-8351 Attorney Requests: (209) 567-5755, ext 4755
Arrowhead Radiology Medical Group	Radiology Services	Arrowhead Radiology Medical Group PO Box 2006, San Bernardino, CA 92406 (909) 580-1520
Cal Med Physicians and Surgeons	Surgical Services	Cal Med Physicians and Surgeons 410 Alabama St., Suite 105 Redlands, CA 92374 (909) 580-6334
California University of Science and Medicine	Neurology Services	California University of Science and Medicine 217 Club Center Dr. San Bernardino, CA 92408 (909) 580-6334

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Joe Baca, Jr. Fifth District
Leonard X. Hernandez Chief Executive Officer

CEP America (Vituity)	Emergency Medicine	CEP America (Vituity) 430 N Vineyard Ave., Ontario, CA 91764 Patient Inquiries: 1-800-498-7157 Spanish Inquiries: 1-800-952-8351 Attorney Requests: (209) 567-5755, ext 4755
City of Hope Medical Foundation	Oncology Services	City of Hope Medical Foundation 1500 E Duarte Rd. Duarte, CA 91010 (626) 775-3200
Faculty Physicians & Surgeons of LLUMC	Cardiovascular Services	Faculty Physicians & Surgeons of LLUSM 11175 Campus Street, Suite 11120 Loma Linda, CA 92354 (909) 651-5582
Faculty Physicians & Surgeons of LLUMC	Urology	Faculty Physicians & Surgeons of LLUSM 11175 Campus Street, Suite 11120 Loma Linda, CA 92354 (909) 651-5582
Inland Empire Anesthesia Medical Group	Anesthesia Services	Inland Empire Anesthesia Medical Group 310 North Indian Hill Blvd., #601 Claremont, CA 91711 (909) 580-2440
Kris J. Storkersen, M.D., Inc.	Ophthalmology	Kris J. Storkersen, M.D., Inc. 400 N Pepper Ave., Colton, CA 92324
Jeffrey N. Roberts, M.D., Inc.	Otolaryngology	Jeffrey N. Roberts, M.D., Inc. 400 N Pepper Ave., Colton, CA 92324
California University of Science and Medicine	Gastroenterology Services	California University of Science and Medicine 217 Club Center Dr. San Bernardino, CA 92408 (909) 580-6334
Inland Medical Rehabilitation	Rehabilitation Services	Inland Rehabilitation Services 400 N Pepper Ave., Colton CA 92324 (909) 580-6250
Mojave Radiation Oncology Medical Group Inc.	Radiation Oncology Services	Mojave Radiation Oncology 2650 Elm Ave. Ste. 201 Long Beach, CA 90806 (909) 887-8800

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Arrowhead Pediatric Medical Group	Neonatal Services	Arrowhead Pediatric Medical Group 400 N Pepper Ave., Colton, CA 92324 (909) 580-6315
Quantum Healthcare Medical Associates Inc.	Internal Medicine & Neurology Services	Quantum Healthcare Associates 5000 Hopyard Road, Suite 100 Pleasanton, CA 94588
San Bernardino Medical Orthopedic Group, Inc.	Orthopedic Services	San Bernardino Medical Orthopedic Group, Inc 1901 W. Lugonia Avenue, Ste 230 Redlands, CA 92374 (909) 557-1601
Valley Obstetrics and Gynecology Medical Group	Obstetrics and Gynecology Services	Valley Obstetrics and Gynecology Medical Group (909) 580-6250 400 N Pepper Ave., Colton CA 92324

Patients will be financially responsible for any services provided by the listed providers. Please keep in mind that the above-mentioned medical groups may also offer financial assistance to patients; you may contact them for more information.

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