

Application for Charity Care and Financial Assistance

Medically Indigent Services Program (MISP)
PO BOX 9610 Moreno Valley, CA 92552

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This application is for you to apply for Riverside University Health System Medical Center Charity Care and/or Financial Assistance Discount Programs.

Eligibility determination will be completed upon receipt of the following documents:

- Complete signed application
- Copy of Picture Identification
- Proof of current Family income (recent paystubs or income tax return)
- If no income – Statement of support

Income Guidelines for each program:

- Charity Care (Free of Charge) – 100% of Federal Poverty Limit
- Financial Assistance Discount Program - 400% of Federal Poverty Limit

Failure to submit all required documentation with the application will result in an incomplete application and failure to comply denial. The application process may take approximately 30 days from the date the application is received.

This application for Charity Care and Financial Assistance Discount Programs are for Riverside University Health System Medical Center (RUHS) charges only and does not apply to ER physician, contracted surgeons, radiology physicians, bills from these contracted providers cannot be discounted by Riverside University Health System Medical Center (RUHS).

Financial Assistance Policy is available: RUhealth.org

Charity Care and Financial Assistance Application**Patient Name:** _____ **DOB:** _____**Address:** _____**City:** _____ **State:** _____ **Zip Code:** _____**Mailing Address:** _____**City:** _____ **State:** _____ **Zip Code:** _____**Telephone Number:** _____**Account No.:** _____ **MRN:** _____**Section A – Medical Assistance Screening** – Circle “Y” for Yes “N” for No

1. Is the patient under age 21 or over age 65? **Y | N**
2. Is the patient a single parent of a child under age 21? **Y | N**
3. Is the patient a caretaker or guardian of a child under 21? **Y | N**
4. Is the patient a married parent of a minor child? **Y | N**
5. Is the patient pregnant, or was the admission pregnancy related? **Y | N**
6. Will the patient potentially be disabled for 12 months? **Y | N**
7. Is the patient a Victim of Crime? **Y | N**
8. Does the patient have a “COBRA” or insurance policy that the premium has lapsed?
 Y | N

Section B Family – List all persons living in the house (yourself, spouse, significant other & all dependents)

First & Last Name	DOB	Relationship

If additional space is needed use page 4

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Section C – Income -

Employment – Are you, your spouse, significant other or your dependents working? Y | N

Name of Person Working	Gross Monthly Income	Type of Work

Self-Employed –

Name of Person Working	Gross Monthly Income	Business Name

Additional Unearned Monthly Income (Social Security Retirement/Disability, Disability (State), Unemployment, Alimony or Child Support):

Name of Person Receiving	Monthly Income	Type of Unearned Income

Section D – Attestation of Truth

I hereby acknowledge all of the information is true and correct. I understand that providing false information will result in the denial of this application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services may be considered an unlawful act. I also acknowledge and consent that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Riverside University Health System Charity Care Program and Financial Assistance is “Payor of Last Resort” and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for fitness or injury, for which Riverside University Health System or its’ subsidiaries provide care.

Patient/Guarantor Signature

Date

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