GLENDORA HOSPITAL
A COLLEGE BEHAVIORAL HEALTH HOSPITAL

Financial Assistance Application Instructions

If you need help paying your medical bills, you may be eligible for financial assistance from Glendora Hospital. Any individual whose family income is at or below 400% of the Federal Poverty Level and is either uninsured or has high medical costs, may be eligible for the hospital's charity (free) care or discounted care or any charge for "care that is reduced but not free". To determine eligibility for financial assistance, please follow the instructions below in completing the Financial Assistance Application, including submission of supporting documentation, as applicable.

You may be eligible for government programs. Medi-Cal provides immediate temporary Medi-Cal coverage based on self-reported patient information. For more information: please visit the following website:

https://files.medi-cal.ca.gov/pubsdoco/presuptive/eligibilty/PE programs landing.aspx

1. **Completion:** 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. **Discounted Care or any charge for care for any service that is reduced but not free:** Eligibility will be based on income consistent with the application of the federal poverty level, and documentation of income is limited to recent paystubs or income tax returns. Glendora Hospital can accept other forms of documentation of income, but it is not required. Patients are required to participate in screening for Medi-Cal eligibility.
3. **Charity (Free) Care:** Eligibility will be based on income consistent with the application of the federal poverty level, and documentation of income is limited to recent paystubs or income tax returns. Glendora Hospital can accept other forms of documentation of income, but it is not required. Patients are required to participate in screening for Medi-Cal for eligibility.
4. **Application Deadline:** Under the renumbered HSC section 127405(e)(3), eligibility for discounted payments or charity care/free care it shall be determined at any time, and Glendora Hospital shall not impose time limits for applying for charity care/free care or discounted payments, nor deny eligibility based on the timing of the patient's application.
5. **Contact Information:** Please call the Patient Account Representative at phone number 562-256-8314 or mail the application to the following address:

College Medical Center
P. O. Box 16421
Long Beach, CA 90806

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PATIENT FINANCIAL ASSISTANCE APPLICATION

Please fill out the patient financial assistance application to the best of your ability. Provide your current Pay Stubs or your 1040 Federal Tax Forms showing your wages and earnings.

ACCOUNT/MEDICAL RECORD NUMBER: _____

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

SPOUSE INFORMATION

RESPONSIBLE PARTY NAME	LAST	FIRST	M.I.
PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY:			

ADDRESS CITY STATE ZIP	
EMPLOYER:	CONTACT PERSON/PHONE #
OCCUPATION:	WORK/CELL PHONE:

LIST ALL DEPENDENTS

NAME	RELATIONSHIP	AGE

MONTHLY INCOME

	PATIENT/RESPONSBILE PARTY	SPOUSE
GROSS WAGES (BEFORE DEDUCTIONS)		

OTHER INCOME

INTEREST & DIVIDENDS		
REAL ESTATE RENTAL/LEASE		
SOCIAL SECURITY		
UNEMPLOYMENT/DISABILITY		
ALIMONY/CHILD SUPPORT		

MONTHLY EXPENSES

RENT/MORTGAGE	
ALIMONY/CHILD SUPPORT	
FOOD/SUPPLIES	
CHILDCARE/SCHOOL	
UTILITES (GAS, electric, water, phone etc.)	
INSURANCE PREMIUMS (Medical, home, auto)	
AUTO PAYMENTS	
TRANSPORTATION EXPENSES (fuel, repair cost)	
CREDIT CARE/PERSONAL LOAN PAYMENTS	
CURRENT MEDICAL PAYMENTS	
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 Glendora Hospital to verify any information listed in this application.

Patient Signature: _____

Date: _____

Spouse Signature: _____

Date: _____

Parent/Guardian: _____

Date: _____