SAN GORGONIO
MEMORIAL HOSPITAL

PATIENT NOTICE OF FINANCIAL ASSISTANCE FOR LOW INCOME OR UNINSURED FAMILIES

SAN GORGONIO MEMORIAL HOSPITAL

San Gorgonio Memorial Hospital is proud of its mission to provide quality care to all who need it, regardless of the ability to pay. Please note San Gorgonio Memorial Hospital accepts most insurances, including: Medicare, Medi-Cal, and most HMO and PPO plans.

If you do not have health insurance and worry that you may not be able to pay in full for your care, we may be able to help you. San Gorgonio Memorial Hospital provides financial assistance to patients based on their income and needs. Through our financial counseling services we may be able to get you qualified for financial aid based on Federal poverty guidelines. There is a discounted sliding fee schedule available based on family size and income. And we will work with you to arrange a manageable payment plan, if there is any balance left, after the application is processed.

In addition, in compliance with California Assembly Bill 774, you may qualify for a discount on your hospital bill if you are a financially qualified patient. Information on our charity and discount policy is available at your request, on the website at www.sgmh.org, or in the Patient Access or Patient Financial Services offices. Also, an amendment was passed through Assembly Bill 1503, which now allows for the availability of charity care and discounted payments for the emergency room physician fees, which are separate from the San Gorgonio Memorial Hospital billing.

It is important that you let us know if you will have trouble paying your bill. Federal and State laws require all hospitals to make reasonable efforts to collect payment for services from patients. The hospital may turn unpaid bills over to a collection agency, and we would like to work with you to avoid this situation.

Patients that only apply for discounted payment may received less financial assistance than what may be available under the charity care program.

We will treat your questions and all information supplied with confidentiality and courtesy.

For more information:

Please contact the Business Office at (951) 769-2173 or (951)-769-2183

Please refer to the 'Help Paying Your Bill' section at www.sgmh.org

Applications can be returned by mail or in person to:

San Gorgonio Memorial Hospital

Attention: Patient Financial Services Department

600 N. Highland Springs Ave

Banning, CA 92220

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STATEMENT OF FINANCIAL CONDITION .

ALL INFORMATION MUST BE FILLED OUT AND ALL DOCUMENTATION REQUESTED MUST ACCOMPANY THE APPLICATION FOR IT TO BE PROCESSED.

PATIENT NAME_____ SPOUSE NAME _____
ADDRESS _____ PHONE _____
PATIENT SSN _____ SPOUSE SSN _____

(OPTIONAL) (OPTIONAL)

FAMILY STATUS: List all dependents that you financially support:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT AND OCCUPATION

Employer:_____ Position_____

Contact Person & Telephone_____

If self employed, Name, address and type of business:

CURRENT MONTHLY INCOME ADD: Patient Spouse

_____ _____

Gross Pay (before deductions)_____ _____

_____

Income from Operating Business (if self employed)

_____

*Please attached Profit and Loss statement or most recent tax return if self employed)

OTHER INCOME: Patient: Spouse:

ADD:

Interest and Dividends_____ _____

From Real Estate _____ _____ Personal Property _____ _____

Social Security Income _____ _____

Subtract: any Alimony or Support Payment _____

Total Current Monthly Income _____

IN ADDITION, PLEASE PROVIDE ALL REQUIRED DOCUMENTS SHOWN IN LIST BELOW:

Recent paycheck stubs, or disability or social security payments stubs, or unemployment check copies or the most current tax return showing the income for the year in which the patient was first billed or 12 months prior to when the patient was first billed (if currently unemployed/self employed).

Proof of identity (i.e. driver's license, California ID card)

And Description of hardship letter (i.e. loss of employment, etc.) • If you have no insurance - Please provide determination letter from

Medi-cal/MISP, Riverside County Health, SSI etc. if applicable

By signing this form, I agree to allow San Gorgonio Memorial hospital to check employment and verify all documents and information supplied for the purpose of determining my eligibility for the charity care program or a financial discount. I understand I will be required to provide proof as stated above in order to complete this application and determine.

_____ _____ _____

Signature of Patient or Responsible party/Guarantor Date

_____ _____ _____

Signature of Spouse Date

NOTE: If there is a dispute or disagreement of the outcome of the charity care application, you can reach out to either of the following person:

Patient Financial office Director at:

Phone number: 951-769-2170

Email: sgmhbilling@sgmh.org