Redlands Community Hospital

Redlands Community Hospital
Financial Assistance

1. Please complete *all* areas on the attached application form. If any areas do not apply to you, write N/A in the space provided.

2. Attach an additional page if you need more space to answer any question.

3. You *must* provide proof of identity. (Only one person in a family needs to provide an identity document). The following documents are accepted as proof:
   - California driver's license
   - Identification card issued by the department of Motor Vehicles
   - U.S. citizenship or alien status documents (passport)
   - Social Security card or document containing a Social Security number

4. Provide proof of income when you submit the attached application. The following documents are acceptable:
   - Recent Tax Return (recent tax returns are tax returns which document a patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed)
     or;
   - Two most recent pay stubs (recent paystubs are paystubs within a 6-month period before or after the patient is first billed)

   Redlands Community Hospital may accept other forms of documentation of income.

5. Your application cannot be processed until *all* required information is provided.

6. It is important that you complete and submit the attached application along with all the required documents.

7. You *must* sign and date the application.

8. If you have any questions, please call (909) 335-5534 x: 5580

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

Submit your completed application:

By Mail:
Redlands Community Hospital
Attn: Business Office
350 Terracina Blvd
Redlands, Ca 92373

In Person:
Redlands Community Hospital
Cashier Office
350 Terracina Blvd
Redlands, Ca 92373

Fax:
909-307-5057

Email:
RCHFIS@redlandshospital.org

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

For assistance in other languages or to access this document in alternative formats, please visit https://www.redlandshospital.org/patient-visitors/for-patients/insurance-billing/financial-assistance-policy-fap-help-paying-your/language-tagline/

Redlands Community Hospital

Application for Financial Assistance

(Section 1) Tell us about the patient who is interested in Financial Assistance

1) Account Number (s): _____
2) Patient Name: _____
3) Home Address: _____
_____
4) Home Phone #: _____ Work Phone #: _____
5) Was this visit due to an Accident? Yes or No
6) Do you have Insurance? Yes or No
a) If yes, Name of Insurance: _____

(Section 2) Dependents (include spouse children under 18, and all others claimed on your tax return)
Name: (First, Middle and Last Name if different than Patient) **Date of Birth**

_____ _____
_____ _____
_____ _____
_____ _____

(Section 3) List *ALL* income/money received by persons listed in Section 1 and 2.

Employment/Source of Income (Patient/ Responsible Party)

Employer Name:			
Hourly Rate:	$	Hours Worked Per Week:	
Current Gross- Weekly, Monthly, or Yearly Income (before taxes)			$
If unemployed, date last worked:			

Spouse Employment/Source of Income

Employer Name:			
Hourly Rate:	$	Hours Worked Per Week:	
Current Gross- Weekly, Monthly, or Yearly Income (before taxes)			$
If unemployed, date last worked:			

I hereby acknowledge that the above listed information submitted is true to the best of my knowledge and belief and the documents are true and correct.

Signature: _____ Date: _____