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

ARROWHEAD REGIONAL MEDICAL CENTER

The Heart of a Healthy Community™

QUESTIONS?
(909) 777-0740
(909) 777-0763

ARROWHEAD REGIONAL MEDICAL CENTER
APPLICATION FOR FINANCIAL ASSISTANCE

400 N. PEPPER AVE
COLTON CA 92324
ATTN: PATIENT ACCOUNTS DEPARTMENT
e-mail: patientaccounts@armc.sbcounty.gov
Phone: 1-877-818-0672
Fax: (909) 777-0815

This application is for you to apply for Arrowhead Regional Medical Center's Financial Assistance Programs, which include the (1) Charity Care Program and (2) Discount Payment Program. The criteria for eligibility for these programs can be found in Arrowhead Regional Medical Center's Charity Care and Patient Discount Payment policies.

Select the program you are applying for:

☐ Charity Care Program (free care)
☐ Discount Payment Program (reduced charges)

To make your application complete, the following documentation must be included:

- Copy of picture identification
- Proof of Family income (recent paystubs or income tax returns only)
- 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 30 days from the date the application is received.
Patients that apply only for the Discount Payment Program may receive less financial assistance than what may be available under the Charity Care Program.

This application is for Arrowhead Regional Medical Center (ARMC) charges, including professional services provided by providers contracted with ARMC only and does not apply to Professional Fees charges, which are billed separately by your provider, such as Physicians, Anesthesiologist, Radiology, Laboratory, etc. These charges will be your responsibility.

Arrowhead Regional Medical Center maintains a list of non-covered providers. You can access the list online at
https://www.arrowheadregional.org/patients-visitors/help-paying-your-bill/
or you may request a copy by calling
ARMC – Patient Accounts department 1-877-818-0672.

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME _____ SPOUSE _____

ADDRESS _____ PHONE _____

CITY _____STATE _____ ZIP CODE _____

EMAIL ADDRESS _____

GUARANTOR#: _____ DATE OF BIRTH _____

MRN _____

FAMILY STATUS:

- If the patient is 18 years or older, please list the following: spouse, domestic partner, dependents under age 21, and/or dependents of any age if disabled.
- If the patient is under 18 years of age or for a dependent child 18 to 20 years of age, please list the parent, caretaker relatives, and parent's or caretaker's relatives' other dependent children under 21 years of age, or any age if disabled.

(If additional space is needed, please use page 5)

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION

Employment: _____Position: _____

If self-employed, Name of Business:
_____

Spouse's Employment: _____ Position:_____

If self-employed, Name of Business: _____

CURRENT MONTHLY INCOME

	Patient	Spouse
Monthly Gross Wages	_____	_____
Section A (Income-Unearned):		
Social Security Pension	_____	_____
Retirement or VA benefits	_____	_____
Unemployment	_____	_____
Alimony or Child Support Payments Received	_____	_____
Other (specify)	_____	_____
Total Income:	_____	_____

Please circle one:

Are you eligible for MEDICARE: YES___ NO__
Are you eligible for MEDI-CAL: YES___ 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 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 an act.

_____ _____

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

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Additional Space for comments: