MOUNTAINS COMMUNITY HOSPITAL
The Heart of Mountain Healthcare

San Bernardino Mountains Community Hospital District Charity Care Application

INSTRUCTIONS

1. Please complete *all* areas on the attached application form. If any area does 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 income documents when you submit this application. The following documents are accepted as proof of income:

   PLEASE PROVIDE PROOF OF INCOME FROM ONE OF THE FOLLOWING BELOW. FAILURE TO PROVIDE THE CORRECT DOCUMENTATION WILL RESULT IN YOUR APPLICATION BEING REJECTED.

   # 1. If you filed a federal income tax return you must submit a copy of:
   a. Federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service;

   # 2. If you did not file a federal income tax return, you must submit the following:
   a. Two (2) most recent paycheck stubs; **and**
   b. Signed Declaration (form CC1) explaining why you did not file a federal income tax return for the prior tax year.

   #3. If you have no income, or proof of income documents, you must provide Signed Declaration (form CC1) explaining how you support yourself/family.
   The Hospital will take this into consideration.
   YOU MAY BE REQUIRED TO APPLY FOR COUNTY PROGRAMS PRIOR TO CONSIDERATION FOR CHARITY CARE.

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

5. It is important that you complete and submit the financial assistance application along with all required attachments within fourteen (14) days.

6. You *must* sign and date the application. If the patient/guarantor and spouse provide information, both *must* sign the application.

7. If you have questions, please call your account representative.

8. Send your completed application to:

   San Bernardino Mountains Community Hospital District
   Patient Financial Services Department
   Attn: Customer Service
   PO Box 70 ~ Lake Arrowhead, CA 92352

San Bernardino Mountains Community Hospital District
Charity Care Application

PATIENT/ GUARANTOR NAME		**SPOUSE NAME**	
Address		**Home Phone**	
		Work Phone	
SOCIAL SECURITY NUMBER			
Patient/ Guarantor		**Spouse**	

Please list MCH account numbers to be considered for charity care:				

FAMILY STATUS
List all dependents that you support

Name	Age	Relationship

EMPLOYMENT STATUS	
Patient/Guarantor Employer	**Position**
Contact Person	**Telephone**
Spouse Employer	**Position**
Contact Person	**Telephone**

INCOME		
	Patient/Guarantor	**Spouse**
1. Gross Wages & Salary/Year (before deductions)		
2. Self-Employment Income/Year		
3. Other Income:		
3. Interest & Dividends		
4. Real Estate Rentals & Leases		
5. Social Security		
6. Alimony		
7. Child Support		
8. Unemployment/Disability		
9. Public Assistance		
10. All Other Sources (attach list)		
Total Income (add lines 1 - 10 above)		

FORM CC1

CHARITY CARE DECLARATION REGARDING INCOME:

I, (name) _____, residing at

_____

Street Address County City and State

Do certify or declare under penalty of perjury under the laws of the State and County above that:

I did not file income taxes for the most prior tax year and the reason I did not file taxes
is:_____
_____
_____
_____
_____

If I am declaring that I have no income at all for the most recent tax year, I support myself and my family
by:_____
_____
_____
_____
_____
_____
_____

_____

Signature of Declarant Dated

UNUSUAL EXPENSES	
Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (attach list as needed).	
Description	**Amount**

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Hospital District to verify any information listed in this application. We expressly grant permission to contact my/our employer.

_____
Signature of Patient/Guarantor

_____
Date

_____
Signature of Spouse

_____
Date