Colorado River MEDICAL CENTER
We are here for you!

1401 Bailey Avenue
Needles, CA 92363
(760) 326-7100 Tel
(760) 459-2208 Fax

EXHIBIT B

Account Number(s)_____

PATIENT DISCLOSURE REPORT

The purpose of this information request is to determine your ability to pay for services at Colorado River Medical Center or your possible eligibility for our Underinsured/Uninsured Patient Discount and Charity Care Policy. This information is **not** an application for Medi-Cal, Arizona Medicaid, or any San Bernardino County assistance program. CRMC's Financial Counselor will provide you with a copy of these applications upon request. If you have been denied by Medi-Cal or the County for Medical Financial Assistance, submit a copy of this denial with this form.

I _____ (print name) certify the following information to be accurate and complete. I understand Colorado River Medical Center reserves the right to verify all information supplied, including a credit check. I agree to notify the Business Office of any change in my financial information within 10 days of the change. **I UNDERSTAND THAT UNTIL AN UNDERINSURED/ UNINSURED PATIENT DISCOUNT AND CHARITY CARE POLICY GRANT HAS BEEN MADE, I AM STILL RESPONSIBLE FOR THE FULL AMOUNT OF MY CHARGES AT COLORADO RIVER MEDICAL CENTER.**

Eligibility determination is based on review of the following items:

- Completed and signed application for consideration of financial assistance
- Recent tax return from the year you were first billed or from the 12 months prior to that billing date ***OR***
- Recent paystubs dated within the 6-month period before or after you receive your first bill (or at the time of your application if applying before services are rendered)

Please call our Business Office at (760) 326 - 7123 for the necessary paperwork or if you have any questions.

_____
Signature of Patient/Responsible Party

_____ _____
CEO Date

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____ SPOUSE _____

ADDRESS _____PHONE _____
ACCOUNT # _____SSN _____ _____
(PATIENT) (SPOUSE)

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FAMILY STATUS: Please list all individuals who live in your household and are financially dependent on you. This may include your spouse, children under the age of 18, or other family members for whom you provide primary financial support.

Full Name of Household Member1: _____

Relationship to you: _____ Age: _____ Income: _____

Full Name of Household Member 2: _____

Relationship to you: _____ Age: _____ Income: _____

(Include additional members if necessary.) Total number or family/household members: _____

EMPLOYMENT AND OCCUPATION

Employer _____ Position _____

Contact Person & Phone Number _____

If Self-Employed, Name of Business _____

Spouse Employer _____ Position _____

Contact Person & Phone Number _____

If Self-Employed, Name of Business _____

CURRENT MONTHLY INCOME

	Patient	Spouse
Add: Gross Pay (before deductions) Income from Operating Business (if Self-Employed)	_____	_____
Add: Other Income:		
Interest and Dividends	_____	_____
From Real Estate or Person Property	_____	_____
Social Security	_____	_____
Other (specify)	_____	_____
Alimony or Support Payments Received	_____	_____
Subtract: Alimony, Support Payments Paid	_____	_____
Equals: Current Monthly Income	_____	_____
Total Current Monthly Income (add patient + spouse income from above)	_____	

	Yes	No
Do you have Health Insurance?	____	____
Do you have other insurance that may apply (such as an auto policy)	____	____
Were your injuries caused by a third party (such as during a car accident, slip or fall)?	____	____

Applying for Charity Care: ____ or Discount Payment ____ or Both _____

By signing this form, I understand that I may be required to provide proof of the information I am providing.

_____ _____ _____

Signature of Patient or Guarantor Signature of Spouse Date