Parkview Community Hospital Medical Center
AHMC Healthcare

Financial Assistance 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 when you submit this application. The following documents are accepted as proof of income:

   If you filed a federal income tax return you must submit a copy:
   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;
   b. Federal W-2 Form showing wages and earnings;
   c. Two (2) most recent paycheck stubs.
   d. **Two (2) consecutive bank statements; ALL PAGES**

   If you did not file a federal income tax return, OR if financial information has changed since your income tax return was filed, please provide the following:
   e. Two (2) most recent paycheck stubs;
   f. Two (2) most recent check stubs from any Social Security, child support, unemployment, disability, alimony or other payments;
   g. **Two (2) consecutive bank statements; ALL PAGES**
   h. If you are paid only in cash, please provide a written statement explaining your income sources.

   <u>If you have no income, please provide a letter explaining how you support yourself/family.</u>

4. Your application cannot be processed until ***all*** required information is provided.
5. It is important that you complete, sign 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:

   AHMC Health Care
   Patient Financial Services Department
   3865 Jackson Street
   Riverside, CA 92503

Parkview Community Hospital Medical Center
Financial Assistance Application

PATIENT/ GUARANTOR NAME		**SPOUSE NAME**	
ADDRESS		**PHONE**	
		Home/Cell	
		Work	
SOCIAL SECURITY NUMBER			
Patient/ Guarantor		**Spouse**	

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 (before deductions)		
2. Self-Employment Income		
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)		

UNUSUAL EXPENSES	
Please provide information on any unusual expenses such as medical bills.	
Description	**Amount**

ASSETS		
Please provide an accurate estimate of value for each asset you own. Also, indicate how much you owe on any outstanding debt related to each asset listed.		
Asset	**Value**	**Amount Owed**
1. Primary Residence		
2. Other Real Estate (attach list)		
3. Motor Vehicles (attach list)		
4. Other Personal Property		
5. Bank Accounts & Investments		
6. Retirement Plans		
7. Other Assets (attach list)		
Total Amounts (add lines 1 – 7 above)		

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Parkview Community Hospital Medical Center to verify any information listed in this application. We expressly grant permission to contact my/our employer, banking and lending institutions, and to check my/our credit history.

_____ _____

Signature of Patient/Guarantor Signature of Spouse

_____ _____

Date Date

Eligibility for financial assistance shall be determined solely by the patient's and/or patient guarantor's ability to pay. Eligibility for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

The patient/guarantor bears the burden of establishing eligibility for qualification under any financial assistance program. Patients/guarantors are required to provide timely, honest and complete disclosure in order to obtain financial assistance. The hospital will provide guidance and/or direct assistance to patients or their guarantors as necessary to facilitate completion of government low-income program applications when the patient may be eligible. Assistance will also be provided for completion of an application for the PCHMC Financial

Financial Assistance Program qualification is determined after the patient and/or patient guarantor establishes eligibility according to criteria contained in this policy. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the hospital retains full discretion to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.