



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 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 _____
ADDRESS _____
ACCOUNT # _____

SPOUSE _____
PHONE _____
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 of 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
<i>Add:</i> Gross Pay (before deductions)	_____	_____
Income from Operating Business (if Self-Employed)	_____	_____

<i>Add:</i> Other Income:		
Interest and Dividends	_____	_____
From Real Estate or Person Property	_____	_____
Social Security	_____	_____
Other (specify)	_____	_____
Alimony or Support Payments Received	_____	_____

<i>Subtract:</i> Alimony, Support Payments Paid	_____	_____
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<i>Equals:</i> 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)	_____	_____
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Were your injuries caused by a third party (such as during a car accident or slip and fall)?	_____	_____
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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