El Centro Regional Medical Center
Financial Assistance Application

If you need help paying your medical bill, you may be eligible for financial assistance from El Centro Regional Medical Center ("ECRMC"). This financial assistance applies to your hospital bill only, and it does NOT apply to bills you may receive from your physicians or surgeons.

ECRMC provides financial assistance to patients with medically necessary health care needs who are low-income based on their individual family financial situation and insurance status.

Based on current Federal Poverty guidelines, you may qualify for free or discounted care. If your family income is at or below 200% of the Federal Poverty Level, you may be eligible to receive hospital services at no cost to you, otherwise known as full charity care. If your family income is between 201% to 400% of the Federal Poverty Level, you may be eligible to receive discounted care. Under discounted care, your payment is reduced but not free.

To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please complete this form and provide the most recent supporting documentation: An income tax filing (which document the patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed) **or** 2 pay check stubs within a 6-month period before or after the patient is billed by the Hospital, or in the case of a pre-service application, when the financial assistance application is submitted.

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. Please note that based on eligibility, discount payment offers less financial assistance than charity care.

3. Attach an additional page if you need more space to answer any question.

4. For purposes of determining eligibility, please submit documentation of income limited to (i){ paystubs within six months before or after the patient is first billed **or** (ii) income tax returns from the year the patient was first billed or 12 months prior to when the patient was first billed.

5. If you are insured and claiming High Medical Costs[1] based on High Medical Costs incurred outside of ECRMC, please provide documentation showing all medical expenses paid by you or your family in the prior 12 months.

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

7. It is important that you complete and submit the financial assistance application along with all required attachments.

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

9. If you have questions, please call your financial counselors at (760) 339-7277.

10. Send your completed application to:
    El Centro Regional Medical Center
    Patient Financial Services Department
    1271 Ross Avenue
    El Centro, CA 92243

El Centro Regional Medical Center

[1] High Medical Cost is defined as annual out of pocket costs incurred by the individual at the hospital that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months, or, annual out of pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or patient's family in the prior 12 months.

Financial Assistance Application

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

LIST ALL FAMILY MEMBERS[2]		
Name	**Age**	**Relationship**

[2] Family is defined as:

(i) For persons 18 years of age and older, spouse, domestic partner, dependent children under 21 years of age, or any age if disabled, whether living at home or not, and

(ii) For persons under 18 years of age or for a dependent child 18 to 20 years of age, parent, caretaker relatives, and other children under 21 years of age, or any age if disabled, of the parent or caretaker relative.

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

INCOME		
	Patient/Guarantor	**Spouse**
Gross Wages/Year (before deductions)		

ESSENTIAL LIVING EXPENSES		
Rent/Mortgage $_____	Utilities $_____	Food $_____
Child Support $_____	Alimony $: _____	Loans $_____
Insurance Premiums $: _____	Medical $_____	

ELIGIBILITY (MUST MEET ONE)

<table>
<tr><td rowspan="4">Patient is uninsured?

YES: ☐</td><td colspan="2">Patient has high medical costs? (Check YES if either box B1 or B2 is more than box A)

YES: ☐</td></tr>
<tr><td colspan="2">A: 10 percent of the patient’s current family income or family income in the prior 12 months (whichever is lower):

_____ (10% of patient’s current or last 12 month family income – whichever is lower)</td></tr>
<tr><td>B1: Annual out-of-pocket costs incurred by the patient at the hospital: $_____</td><td>B2: Annual out-of-pocket medical expenses paid by the patient or patient’s family with supporting documentation:
$_____</td></tr>
<tr><td colspan="2"></td></tr>
</table>

Please check the type of financial assistance you are interested in applying for (most patients will check both boxes):

☐ Full Charity Care
☐ Discount Payment: Patients applying only for the Discount Payment Program may receive less financial assistance than may be available under Charity Care

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

_____ Signature of Patient/Guarantor

_____ Signature of Spouse

_____ Date

_____