EL CENTRO REGIONAL MEDICAL CENTER
FINANCIAL ASSISTANCE OR DISCOUNT APPLICATION INSTRUCTIONS

Instructions

As part of our commitment to serve the community, El Centro Regional Medical Center elects to provide financial assistance to patients/guarantors who are financially indigent or medically indigent and satisfy certain requirements.

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

Please provide the following information and copies of information with your financial assistance or discount application:

1. Statement of Financial Condition
2. Documents to verify income

Please provide of the following:	Please provide a copy of the following:
A. IRS Form W-2, Wage and Earnings Statement for all household earnings;	A. Governmental Assistance, Social Security or Workers' Compensation, if applicable B. Unemployment compensation letter, if applicable

In the event income verification is unavailable, please contact our office for further instructions. Applications without income verification are considered incomplete and will not be processed. For assistance in completing this application, please contact El Centro Regional Medical Center at 760-339-7277, Monday through Friday from 8:00 AM to 5:00 PM. Please return the application and verification of income documents to:

Patient Accounting Department-Financial Counseling
El Centro Regional Medical Center
1415 Ross Avenue
El Centro, California 92243

Please note that physicians providing services at El Centro Regional Medical Center are not employees of El Centro Regional Medical Center. You will receive separate bills from your private physician and from other physicians whose services you required (e.g. surgeon, radiologist, anesthesiologist, pathologist, hospitalist, etc.). The Financial Assistance Application does not apply to any amounts due by you for physician services. For questions regarding their bills, or to make payment arrangements for physician services, please contact the individual physician's office. We will notify you of your eligibility following receipt and review of all necessary information. The notification will be mailed to the mailing address you have provided on the Financial Assistance or Discount Application.

EL CENTRO REGIONAL MEDICAL CENTER
STATEMENT OF FINANCIAL CONDITION

Account Number:	
Patient Name/SSN:	
Guarantor Name/SSN:	
Guarantor Name/SSN:	
Address:	
Phone Number:	

FAMILY STATUS: List all dependents in the household

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION

Employer:	Position:
Contact Person:	Telephone:
If Self-Employed, Name of Business:	

Spouse Employer:	Position:
Contact Person:	Telephone:
If Self-Employed, Name of Business:	

CURRENT MONTHLY INCOME

		Guarantor	Guarantor
ADD	Gross Pay (before deductions)		
	Income from Operating Business (if self-employed)		
	Other Income:		
	Interest and Dividends		
	From Real Estate or Personal Property		
	Social Security		
	Other (specify):		
	Alimony or Support Payments Received:		
SUBTRACT	Alimony, Support Payments Paid		
EQUAL	Current Monthly Income		
	Total Monthly Income (combine both guarantors)		

FAMILY SIZE Total Family Members (Add patient, guarantors and dependents from above)	

By signing this form, I agree to allow El Centro Regional Medical Center to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I am also required to provide the documents outlined in the El Centro Regional Medical Center Financial Assistance and Discount Application.

Signature of Guarantor: _____ Date: _____

Signature of Guarantor: _____ Date: _____