# Financial Assistance Application Instructions

SAN ANTONIO
REGIONAL HOSPITAL

**In order for this application to be considered for Financial Assistance, ALL of the following documents are required, if applicable:**

_____Completed and signed Financial Assistance Application form
_____A copy of most recent Federal Income Tax return with W-2's and Schedules
_____A copy of current pay stubs (**13 weeks**)
_____A copy of social security, disability, or unemployment checks or award letter

Please return your completed application with all requested forms to the following address within 10 days.

**San Antonio Regional Hospital**
Attn: Patient Financial Services
999 San Bernardino Road
Upland, CA 91786

Please contact our Patient Accounting office at the address above or 909-980-9511 if you have any questions.

Please be advised this in not a guarantee that financial assistance will be awarded; and payments should continue on a regular basis until a determination has been made. Your application and the information provided will be reviewed and verified and a decision will be provided to you in writing.

Thank you for your cooperation and for choosing San Antonio Regional Hospital for your healthcare needs. We look forward to being of assistance to you to resolve your account.

# Financial Assistance Application

SAN ANTONIO REGIONAL HOSPITAL

Date: _____

Account/FIN#: _____

| Patient Last Name: | First: | Middle: | Social Security # | Birthdate (mm/dd/yyyy) |
|---|---|---|---|---|
| | | | | |

| Patients Address: (Hospital Address if Homeless) | How long? | Best Contact Phone #: |
|---|---|---|
| | | |

| City | State | Zip | Marital Status |
|---|---|---|---|
| | | | |

| Responsible Party's Name *(If different from above)* | Social Security # | Birthdate (mm/dd/yyyy) | Best Contact Phone #: |
|---|---|---|---|
| | | | |

| Employer Name and Full Address (Responsible Party) | | |
|---|---|---|
| | | |
| Employer Phone #: | | Monthly Gross Pay $: |
| | | |
| Other Employer Name and Full Address (Responsible Party) | | |
| | | |
| Employer Phone #: | | Monthly Gross Pay $: |
| | | |
| If Unemployed, name of Last Employer and Full Address: | | |
| | | |
| Last Employment Dates: From | To / Last Day Worked | |
| | | |

| List Patients Household Members/Dependents: | Birthdate | Relationship | Employed By |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Assets:**

Rent Home ☐

Own Home ☐ Estimated Value of Property: _____

Do you own other property? Yes / No If yes, estimated total value: _____

Checking Account Balance: $_____

Savings Account Balance: $ _____

Do you own automobiles? Yes / No If yes, estimated value: _____

Make: _____ Model: _____

403(b) or 401(k): $_____

Stocks/Bonds: $_____

Total Assets: $ _____

| **Monthly Income** | | **Monthly Expenses** | |
|---|---|---|---|
| Wages - Self | $ | Mortgage/Rent | $ |
| Wages - Spouse | $ | Utilities | $ |
| Wages - Other Family Member within household | $ | Telephone | $ |
| Self Employment | $ | Food | $ |
| Public Assistance | $ | Finance/other loans total | $ |
| Social Security | $ | Auto Loans | $ |
| Unemployment Compensation | $ | Medical Insurance | $ |
| Alimony/Child Support | $ | Auto Insurance | $ |
| Military Family Allotments | $ | Medication | $ |
| Pensions | $ | Other expenses, please list | $ |
| Income from dividends, Interest, Rentals | $ | | $ |
| Any other source of income | $ | | $ |
| **Total Monthly Household Income:** | $ | | $ |
| | | | $ |
| | | **Total Monthly Expenses** | $ |

* I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge
* I agree to tell the provider of services within 10 days, if there are any changes in my (or the persons on whos behalf I am acting) income, property, expenses, or in the persons in the household or of any change of addresses.
* I understand that if I do not qualify for financial assistance, I will be personally liable for the charges of the services rendered by San Antonio Regional Hospital.
* I authorize San Antonio Regional Hospital to verify the information I provided and check my credit history using Experian or other financial tools in order to evaluate this application for Financial Assistance consideration.

| | | |
|---|---|---|
| Patient/Applicant Signature | Drivers License/ID # | Date |
| Spouses Signature | Drivers License/ID # | Date |