400 N. Pepper Avenue, Colton, California 92324-1819 | Phone: 909.580.1000
www.arrowheadregional.org

ARROWHEAD REGIONAL MEDICAL CENTER

The Heart of a Healthy Community™

QUESTIONS?
(909) 777-0740
(909) 777-0763

ARROWHEAD REGIONAL MEDICAL CENTER
FINANCIAL ASSISTANCE DISCOUNT PROGRAM

400 N. PEPPER AVE
COLTON CA 92324
ATTN: PATIENT ACCOUNTS DEPARTMENT

e-mail: patientaccounts@armc.sbcounty.gov
Phone: 1-877-818-0672
Fax: (909) 777-0815

This application is for Arrowhead Regional Medical Center Financial Assistance Discount Payment Program.
Select the program you are applying for:

☐ Charity Care Program (free care)
☐ Discount Payment Program (reduced charges)

To make your application complete, the following documentation must be included:

- Copy of picture identification
- Proof of income (recent paystubs or income tax returns)
- Proof of spouse's income (if applicable) (recent paystubs or income tax returns)
- Statement of support if there is no income

Failure to submit all required documentation with the application will result in an incomplete application.

The application process takes approximately 30 days from the date the application is received.

This application is for Arrowhead Regional Medical Center (ARMC) charges only and coverage may not apply to the Professional Fees incurred, such as Physicians, Anesthesiologist, Radiology, Laboratory, etc. These charges will be your financial responsibility.

Arrowhead Regional Medical Center maintains a list of non-covered providers. You can access the list online at www.arrowheadregional.org/documents/ARMC-NON-COVERED-PROVIDER-LIST,or you may request a copy by calling ARMC-Patient Accounts department 1-877-818-0672.

FINANCIAL ASSISTANCE DISCOUNT PROGRAM

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____ SPOUSE _____

ADDRESS _____ PHONE _____

CITY _____STATE _____ ZIP CODE _____

EMAIL ADDRESS _____

GUARANTOR# _____ DATE OF BIRTH _____

MRN _____

FAMILY STATUS: List all dependents, under age 21 and/or disabled adults, that you support
(If additional space is needed, please use page 5)

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT AND OCCUPATION

Employment: _____Position: _____

If self-employed, Name of Business: _____

Spouse's Employment: _____ Position: _____

If self-employed, Name of Business: _____

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CURRENT MONTHLY INCOME

	Patient	Spouse
Monthly Gross Wages	_____	_____
Section A (Income-Unearned):		
Social Security Pension	_____	_____
Retirement or VA benefits	_____	_____
Unemployment	_____	_____
Alimony or Child Support Payments Received	_____	_____
Other (specify)	_____	_____
Total Income:	_____	_____

Please circle one:

Are you eligible for MEDICARE: YES OR NO

Are you eligible for MEDI-CAL: YES OR NO

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PLEASE AGREE TO THE FOLLOWING INFORMATION

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I understand that I may be required to provide proof of the information I am providing.
- I further agree that in consideration for receiving health care services because of an accident or injury, to reimburse the County from the proceeds of any litigation or settlement resulting from such act.

_____ _____ _____ _____

(Signature of Patient or Guarantor) (Date) (Signature of Spouse) (Date)

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Additional Space for comments: