Ridgecrest Regional Hospital has a Patient Financial Assistance program that may be of assistance to you in paying your bill. Enclosed you will find a Financial Assistance Application for you to complete.

Please fill out the Financial Assistance Application form completely and return it with your proof of income, *for everyone in your household*. **For proof of income you will need to provide at least one of the following**:

- Two recent pay stubs
- A copy of your most current W-2
- Or a recent bank statement (if you have direct deposit)

If you have no income you will need to provide a statement as to how you financially meet your daily needs. If someone is financially assisting you with your daily needs, please have them write a statement stating that they are providing this assistance and how they are doing so.

Please note, you must return the Financial Assistance Application form with appropriate proof of income in order to be considered for this program. Acceptance into this program is decided based on the Federal Poverty Guidelines. We have provided you with a self-addressed stamped envelope in which to return the Financial Assistance Application form and all necessary documentation.

Should you have any questions please feel free to contact me at the number listed below. I'm in the office from 7:30 to 4:00 Monday thru Friday.

Sincerely,

Patricia Townsley
Personal Pay Patient Representative
Ridgecrest Regional Hospital
901 Heritage blvd
Ridgecrest, CA 93555
760-499-3010

RIDGECREST REGIONAL HOSPITAL
Financial Assistance Application

1081 N. China Lake Blvd, Ridgecrest, Ca 93555

Account #_____

All information must be complete for consideration for financial assistance

Patient Information *Parent/Spouse/Guarantor Information*

Name: _____ Name:_____

Address:_____ Address:_____

City/St/Zip:_____City/St/Zip:_____

Monthly Net Income_____ Monthly Net Income_____

Number of Dependents _____
List all other income: $_____ Source_____ $_____Source _____

If unemployed, what is your source of income?_____
(This must be answered if source of income is zero)

Optional: Do you have a _____ Checking account Current balance $_____
_____ Savings account Current balance $_____

You must provide a current bank statement or pay stub or income tax form.

_____

I declare that the above statements are true and correct to the best of my knowledge. I understand that withholding of information or the giving of false information will make the patient and/or responsible party liable for all charges for services.

Signature:_____ Date:_____

revised 3/2001

All lines must be filled out. If not applicable please indicate.

Amount of discount is determined based on income level and Federal Poverty Guidelines. Please refer to the Financial Assistance Program policy available on our website for a complete listing of services covered. Not all Physician professional fees are covered under the Financial Assistance Policy.

Questions: Call 760-499-3010