



1401 Bailey Avenue
Needles, CA 92363
(760) 326-7100 Tel
(760) 459-2208 Fax

EXHIBIT B

Account Number(s) _____

PATIENT DISCLOSURE REPORT

The purpose of this information request is to determine your ability to pay for services at Colorado River Medical Center or your possible eligibility for our Underinsured/Uninsured Patient Discount and Charity Care Policy. This information is **not** an application for Medi-Cal, Arizona Medicaid, or any San Bernardino County assistance program. CRMC's Financial Counselor will provide you a copy of these applications upon request. If you have been denied by Medi-Cal or the County for Medical Financial Assistance, submit a copy of this denial with this form.

I _____ (print name) certify the following information to be accurate and complete. I understand Colorado River Medical Center reserves the right to verify all information supplied, including a credit check. I agree to notify the Business Office of any change in my financial information within 10 days of the change. **I UNDERSTAND THAT UNTIL AN UNDERINSURED/UNINSURED PATIENT DISCOUNT AND CHARITY CARE POLICY GRANT HAS BEEN MADE, I AM STILL RESPONSIBLE FOR THE FULL AMOUNT OF MY CHARGES AT COLORADO RIVER MEDICAL CENTER.**

Eligibility determination is based on review of the following items:

- Completed and signed application for consideration of financial assistance
- Recent tax return
- Pay stubs for the past three months

Please call our Business Office at (760) 326 - 7123 for the necessary paperwork or if you have any questions.

Signature of Patient/Responsible Party

CEO

Date

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____
ADDRESS _____
ACCOUNT # _____

SPOUSE _____
PHONE _____
SSN _____
(PATIENT) (SPOUSE)

