COMMUNITY
MEDICAL CENTERS

PATIENTS NAME:
ACCOUNT NO:
CSN:

Dear ,

Thank you for allowing Community Medical Centers to serve your health care needs.

A Financial Assistance Application is enclosed to determine the possibility of financial hardship. If you are interested in applying, please complete the application and return it to us within the next (15) fifteen business days. Please attach a copy of the following documents with your application:

Proof of Income for all family members in the household:

1. Three (3) recent pay stubs, W-2 or most recently filed Tax Return *or*
2. If self-employed, provide the most recently filed Tax Return (including schedule C) or
3. If unemployed, attach unemployment compensation benefit statement or
4. Retirement/Pension statement (if applicable) or
5. If receiving public assistance, please provide proof of eligibility/current enrollment in any of the following government programs: Medicare Savings Program, Cal WORKS, Cal Fresh (Food Stamps), SSI/SSP (Supplemental Security Income/State Supplementary Payment), or WIC (Women, Infants and Children)

Patients who have medical insurance **must** also provide documents to verify that 10% of the family income has been paid **or** is owed towards medical costs during the past 12 months. All current balances, medical bills/receipts, pharmacy and medical insurance premiums can be applied towards the 10%.

Community Medical Centers is committed to serving our community. We are glad that we were able to assist you in your time of need.

If you have any questions regarding this account, or about the documentation required, please call us at (559) 459-3939 or (800) 773-2223 option #3. An incomplete application cannot be processed.

Mail completed and signed application and documentation to the below address or fax to (559) 230-8505:
Patient Financial Services
Community Medical Centers
PO Box 1232
Fresno, CA 93715-9889

Date form given/mailed _____ Return form by _____

**CMC Financial Assistance Application**

| PATIENT NAME | PATIENT ACCOUNT # |
|---|---|
| | MEDICAL RECORD # |

| **I. PATIENT / RESPONSIBLE PARTY** | |
|---|---|
| LAST NAME | FIRST NAME<br>MIDDLE INITIAL |
| STREET ADDRES | SOCIAL SECURITY # |
| | HOME PHONE |
| | CELL PHONE |
| EMPLOYER'S NAME | BUSINESS PHONE |
| | GROSS MONTHLY INCOME $ |

| **II.SPOUSE / DOMESTIC PARTNER** | |
|---|---|
| LAST NAME | FIRST NAME<br>MIDDLE INITIAL |
| STREET ADDRES | SOCIAL SECURITY # |
| | HOME PHONE |
| | CELL PHONE |
| EMPLOYER'S NAME | BUSINESS PHONE |
| | GROSS MONTHLY INCOME $ |

| **III. HOUSEHOLD INFORMATION** | | |
|---|---|---|
| List spouse, domestic partner, dependent children under 21. If patient is a minor, list all parents, caretaker relatives, and (siblings under 21) | | |
| NAME | DOB | RELATIONSHIP |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **TOTAL PERSONS IN HOUSEHOLD:** | | |

| IV. MONTHLY GROSS INCOME | |
|---|---|
| Patient / Responsibility Party's Monthly Income | $ |
| Spouse/Domestic Partner Monthly Income (If Applicable) | $ |
| Retirement Income | $ |
| Alimony/Support Payments received | $ |
| Unemployment or Worker's Comp | $ |
| Social Security/Social Security Disability | $ |
| Miscellaneous Income | $ |
| If Alimony/Support Payments paid, deduct here | -$ |
| **TOTAL MONTHLY GROSS INCOME =** | **$** |

| V. MISCELLANEOUS INFORMATION | | |
|---|---|---|
| | **Yes** | **No** |
| Are you over 18 and claimed as a dependent on your parents income tax return? | | |
| Are you enrolled in: Medicare Savings Program, Cal WORKS, Cal Fresh (Food Stamps),SSI/SSP (Supplemental Security Income/State Supplementary Payment), or WIC (Women, Infants and Children)? | | |
| Do you have health insurance? | | |
| Was this visit caused by a third party, such as an auto accident or a slip and fall? | | |
| Have you applied for Medi-Cal or Medicare? | | |
| Have you applied for Covered California? | | |

**INCOMPLETE OR FRAUDULENT APPLICATIONS WILL BE DENIED**

IN COMPLETING THIS FINANCIAL STATEMENT, I HEREBY AFFIRM THAT THE ABOVE STATEMENTS ARE CORRECT AND COMPLETE, AND I GIVE MY CONSENT TO FURTHER VERIFICATION BY COMMUNITY MEDICAL CENTERS.

SIGNATURE: _____

PRINT NAME: _____

DATE: _____

RELATIONSHIP IF OTHER THAN PATIENT: _____

Mail completed application and documentation to the below address or fax to (559) 230-8505:

Patient Financial Services
Community Medical Centers
PO Box 1232
Fresno, CA 93715-9889

## Language Assistance Services

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call **1-559-459-6789** (TTY: 1-**1-888-877-5379**).

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1. **Spanish:**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-559-459-6789 (TTY: **1-888-877-5379**).

2. **Chinese:**

注意 :in 9 ft tit t 文,9 TT t *It44- al- AMR.*o ca 1-559-459-6789 (TTY: **1-888-877-5379**)

3. **Vietnamese:**

CHÚ Ý: Nếu ban nói Tiếng Việt, có các djch viii hỗ trợ ngôn ng miễn phí dành cho ban. GQi so 1-559-459-6789 (TTY: **1-888-877-5379**).

4. **Tagalog**:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-559-459-6789 (TTY: **1-888-877-5379**).

5. **Korean:**

7Z -I-01----I: 한국CU-ii 를 A L"i 용하AI 는 경C), 01c...CU-ii T".C! . U"iI-I-i A.-를 무료로(1 용하실 수01 ._ I r 1-559-459-6789(TTY: **1-888-877-5379**) 번으로 전화V 7Z -I-십AI 오

6. **Armenian:**

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերե ն, ապա ձե զան վճա ր կարող ե ն տրամադրվե լ լեզվական աջակցությա ն ծառ այությունն ե ր: Զան գահարե ք1-559-459-6789 (TTY (հեռատիպ)՝ **1-888-877-5379**) :

7. **Persian (Farsi):**

**توجه:** شما برای رایگان بصورت زبانی تسهیلات ،کنید می گفتگو فارسی زبان به اگر بلئد می فراهم. اب (TTY: **1-888-877-5379**) 1-559-459-6789 بگیرید تماس

8. **Russian:**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-559-459-6789 (телетайп: **1-888-877-5379**).

9. **Japanese:**

- 意事項:日本語を話される9 合 無 I.4 ø=語支援をZiJ用 L ただ(fます。1-559-459-6789 (TTY: **1-888-877-5379**)まで、 お電話1 てZ連*
ください。

10. **Arabic:**

ملحوظة : بالمجان لك تتوافر اللغوية المساعدة خدمات فإن ،اللغة اذكر تتحدث كنت إذا. لصتا مقرب (رقم) 1-559-459-6789 (9876-954-955-1?) **( 1-888-877-5379 or 9735-778-888-1?)**:والبكم الصم هاتف

11. **Punjabi:**

ਿ ਯ ਧ ਆ ਨ ਿ ਦਓ: ਜੇ ਤੁਸ~ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ~ ਭਾਸ਼ਾ ਿ ਵ ਯ ਚਸਹ ਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-559-459-6789 (TTY: **1-888877-5379**) 'ਤੇ ਕਾਲ ਕਰੋ।

12. **Mon-khmer, Cambodian:**

[illegible] 1-559-459-6789 (TTY: **1-888-877-5379**).

13. **Hmong:**

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-559-459-6789 (TTY: **1-888-877-5379**).

14. **Thai:**

[illegible] 1-559-459-6789 (TTY: **1-888-877-5379**).

15. **Hindi:**

ध्यान द~: य~द आप ~हदी बोलते ह~ तो आपके ि लए मुफ्त म~ भ्याष्या सह्यायत्या सेव्याएं उपलब्ध ह।~ 1-559-459-6789 (TTY: **1-888-877-5379**) पर कॉल कर~।

**16. Portuguese:**
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-559-459-6789 (TTY: **1-888-877-5379**).

**17. Lao:**
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**18. German:**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-559-459-6789 (TTY: **1-888-877-5379**).

**19. French:**
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-559-459-6789 (ATS : **1-888-877-5379**).

**20. Italian:**
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-559-459-6789 (TTY: **1-888-877-5379**).

TTY Information (Policy 11959)

A.

1. To utilize TDD/TYY services
    a. Dial **711** for TTY/TDD services
        i. 711 will determine if you are using an ADA Tool Kit or a phone and direct your call to the appropriate service
    b. Dial **712** for Text to Voice services if you are using the ADA Tool Kit
    c. Dial **713** for Voice to Text services for English voice service
    d. Dial **714** for Voice To Text services for Spanish voice service
    e. Dial **715** for California Relay Services Customer Services
2. California Relay Services Official Contact numbers: **(Dial 9 to get an outside line)**
    a. For Text to Voice services: **1-877-735-2929** ADA Tool Kit
    b. For Voice to Text services: **1-888-877-5379** English voice services
    c. For Voice To Text services: **1-888-877-5381** Spanish voice services
    d. For Customer Services: **1-800-676-3777** Customer Service (Voice or TTY)