CURRENT MONTHLY INCOME

ADD:	Patient	Spouse
Gross Pay (before deductions)		

Income from Operating Business (if self employed) _____
*Please attached Profit and Loss statement or most recent tax return if self employed)

OTHER INCOME: ADD:	Patient:	Spouse:
Interest and Dividends		
From Real Estate		
Personal Property		
Social Security		
Alimony or Support Payment		
SUBTRACT: Alimony, Support Payment Paid		
Equals: Current Monthly Income		

IN ADDITION PLEASE PROVIDE: REQUIRED DOCUMENTS

- 2 recent paycheck stubs, disability or unemployment check copies or the most current tax return if currently unemployed/self employed.
- Proof of residence (utility bill, mail)
- 2 Recent bank statement(s) for **all** accounts (i.e. checking and savings)
- Proof of citizenship (i.e. driver's license, social security card)
- And Description of hardship letter (i.e. loss of employment, etc.)
- Determination letter from Medi-cal/MISP, Riverside County Health etc. if applicable

By signing this form, I agree to allow San Gorgonio Memorial hospital to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand I will be required to provide proof as stated above.

_____ _____
Signature of Patient or Guarantor Date

_____ _____
Signature of Spouse Date