SAN ANTONIO
REGIONAL HOSPITAL

How to Apply for Help with Medical Bills at San Antonio Regional Hospital

Make sure to read everything before you fill out the form.

When you apply for help to pay for your medical care at San Antonio Regional Hospital (SARH), we will check two different programs. One is called SARH Charity Care program, and the other is called Discount Payment program. To see if you can get help from these programs, your family needs to make a certain amount of money or less.

For SARH Charity Care program:

- For full help, your family must make 300% or less of Federal Poverty Guidelines.
- If your family makes more than 300% of the federal poverty guideline, you might get some help or discounts.

It is important to give SARH all the information we ask for so we can figure out the best way to help you. After you give us all the paperwork we need, you will get a letter within 30 days to let you know if you will get help with your medical bills.

STEP 1: Read the list below and pick the best way to show how much money you make. Attach copies of all the papers. Don't send the original papers because you won't get them back. If you forget to send some papers, it might take longer to review your application, or you might not get help from this program.

Income Type	Requested Documentation
Employment income	Copy of individual tax return (1040 for current tax year) **OR** Copy of two most recent pay stubs
Self-employment	Copy of individual tax return (1040 for current tax year including schedule C).
Social Security/ Retirement	Copy of individual tax return (1040 for current tax year) **OR** Copy of award letter from Social Security stating monthly payment.
Disability	Copy of individual tax return (1040 for current tax year) **OR** Copy of award letter stating disability payment
Unemployment	Copy of individual tax return (1040 for current tax year) **OR** Copy of letter stating monthly award amount

STEP 2. Fill out and sign the attached application.
Need Help with the application? CALL SARH Financial Assistance Department at (909) 980-9511, Monday through Friday, 8:00 am to 5:00pm

STEP 3. Mail your application with all your paperwork to:
Patient Financial Services Attn: Financial Assistance
999 San Bernardino Road Upland, CA 91786
OR you can Email your application and all your paperwork BillingInfo@sarh.org

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Patient Financial Assistance Application

Applicant (Guarantor) Information

Name (first name, middle initial, last name)		Date of Birth (DOB) (mm/dd/yyyy)	
Street address		City, State, ZIP	
Home/mobile phone	Guarantor Account Number	Medical Record Number	Social Security #
Spouse/guardian name (first name, middle initial, last)		Date of Birth (DOB) (mm/dd/yyyy)	
Home/mobile phone		Social Security #	

Will your spouse also be applying for financial assistance? ☐ Yes ☐ No	Applicant Identification Number:	Medical Record Number

FAMILY HOUSEHOLD/DEPENDENTS

Household Size: _____ List the number of family members who live with you in your home, such as a spouse, a qualified domestic partner, and dependent children under age 21 or if disabled any age. Include other disabled dependent children of the patient's caretaker.

Last Name:	First Name:	DOB:	Medical Record Number:
Last Name:	First Name:	DOB:	Medical Record Number:
Last Name:	First Name:	DOB:	Medical Record Number:
Last Name:	First Name:	DOB:	Medical Record Number:

Source of Income	Applicant	Co-Applicant	Combined Monthly Income
Employment/Self Employment			
Social Security			
Disability			
Annuity			
Alimony			
Other			

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FINANCIAL AGREEMENT AND CREDIT REPORT AUTHORIZATION

I promise that everything I wrote in this application is true and correct. All the attached documents are real copies of the originals. I understand it is against the law to lie about this information and I won't get help from this program.

Signature of Patient/Guarantor **X**	Date (mm/dd/yyyy)
Signature of Spouse of Patient/Guarantor **X**	Date (mm/dd/yyyy)

We will send you a letter to let you know if you are able to get help with your medical bills