UC San Diego Health

Financial Assistance Application

Proof of Income Required: Along with your application (pages 2-3), please attach the following information or an explanation as to why this information is not available. Missing documentation may delay the processing of your application and could result in a denial for financial assistance.

Type of Income	Documentation
Employment Income Self-Employment	Submit a copy of your most recent tax return (Form 1040). It must reflect income for the 12 months before you received the bill you are applying for.
Social Security Retirement Social Security Disability	Submit a copy of your most recent tax return (Form 1040). It must reflect income for the 12 months before you received the bill you are applying for. Social Security documentation showing monthly payment amount.
Disability	Submit a copy of your most recent tax return (Form 1040). It must reflect income for the 12 months before you received the bill you are applying for. Copy of Award Letter stating disability payment
Unemployment	Submit a copy of your most recent tax return (Form 1040). It must reflect income for the 12 months before you received the bill you are applying for. Copy of letter stating monthly award amount

Financial assistance is available to those with or without healthcare insurance. Please note that to qualify for assistance, patients with insurance must have incurred health care costs amounting to at least 10 percent of their family income, either at UC San Diego Health or with receipts if incurred elsewhere.

Our Patient Financial Assistance team will make every effort to process your application expeditiously. Please send your completed application and required documents within 20 days to:

UC San Diego Health
Patient Financial Assistance Team 6200 Greenwich Drive, Suite 300 San Diego, CA 92122

Financial Assistance Application

Date of Application_____

Please mark the type of assistance you are requesting:

☐ Charity Care (100% Free Care) ☐ Discount Payment (Reduced Care) ☐ Both

Family Information: Please provide the names of all family members to be considered for financial assistance.

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

Applicant (Guarantor) Information: (circle one

Relationship to Patient

☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other

Marital Status

☐ Single ☐ Married/Domestic Partner ☐ Divorced

Last Name:	First Name:		U.S. Citizen (check one) ☐ Yes ☐ No
Date of Birth:	No. of Dependents	Ages of Dependents:	Phone:
Street Address:			
Employer:	Employer Address:		Position:
If you are not working, how long have you been unemployed?			

Co-Applicant (Guarantor) Information: (circle one

Relationship to Patient

☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other

Marital Status

☐ Single ☐ Married/Domestic Partner ☐ Divorced

Last Name:	First Name:		U.S. Citizen (check one) ☐ Yes ☐ No
Date of Birth:	No. of Dependents	Ages of Dependents:	Phone:
Street Address:			

Employer:	Employer Address:	Position:
If you are not working, how long have you been unemployed?		

Income Information

Monthly Income Sources	Applicant	Co-Applicant	Combined Monthly Income
Employment/Self Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Annuity	$	$	$
Other	$	$	$
Total Combined Monthly Income: $			
Total Number Of Persons In Household:			
If you do not have monthly income, please explain how you take care of your monthly expenses. Use additional pages if necessary.			

Signature

I certify that all information is valid and complete and hereby authorize UC San Diego Health to verify and/or confirm all information included in this application as deemed necessary.

Applicant Date Co-Applicant Date

Please send your completed application and required documents to:

UC San Diego Health
Patient Financial Assistance Team
6200 Greenwich Drive, Suite 300
San Diego, CA 92122

2025 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA		
Persons in family/household	Poverty Guidelines (100%)	Poverty Guidelines (400%)
1	$0 - $15,650	$62,600
2	$0 - $21,150	$84,600
3	$0 - $26,650	$106,600
4	$0 - $32,150	$128,600
5	$0 - $37,650	$150,600
6	$0 - $43,150	$172,600
7	$0 - $48,650	$194,600
8	$0 - $54,150	$216,600
For families/households with more than 8 persons, add $6,880 for each additional person.		