FINANCIAL ASSISTANCE APPLICATION
AND LIST OF REQUIRED SUPPORTING DOCUMENTS

Please return the completed application and supporting documents to:

Cedars-Sinai Medical Center
Financial Assistance Processing Unit, File 1688
1801 W. Olympic Blvd.
Pasadena, CA 91199-1688

Business hours: 8 a.m.–4:30 p.m.
Business days: Monday–Friday
Phone number: 323-866-8600
Email: Patient.Billing@cshs.org

This is the Organization's application for Charity Care or Discount Payment financial assistance. If you have any questions, the contact information is above.

To be considered, please complete this application to help the Organization determine whether you may qualify to receive Charity Care (free care) or a Discount Payment (reduced but not free care). Even if you apply, we cannot guarantee that you will qualify. A written response will be provided to all patients supporting approval/denial after we receive your completed application and documentation.

The Policy only applies to medically necessary services provided by Cedars-Sinai Medical Center, Cedars-Sinai Marina Hospital, Cedars-Sinai Medical Care Foundation ("CSMCF"), Huntington Hospital, Huntington Health Physicians (each separately, the "Organization") as well as by faculty physicians in their capacity as faculty, physicians employed by medical groups that have a professional services agreement with the Organization, and the Cedars-Sinai Medical Center emergency physicians.

You may submit the completed, signed and dated application by mail or email.

- A completed application must include the date and signature of the applicant.
- There are no required deadlines for applying.
- In addition to the application, **provide proof of income documentation** for both you and your spouse/partner (if married, in a civil union or a domestic partnership). This documentation will be either:
    - **Recent tax returns** (These document a patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed.)
    - **Recent paystubs** (Within a 6-month period before or after the patient is first billed by the Organization or in the case of pre-service, when the application is submitted.)
- Missing or unattached documents may cause a delay or denial of financial assistance.

PLEASE NOTE: If you are uninsured and meet specific Medi-Cal presumptive eligibility criteria, you are not required to complete this application.

Patients will not be required to apply for or enroll in any insurance or benefit program, including Medi-Cal. However, the Organization may request a Medi-Cal eligibility screening (without requiring formal application) and will provide patients with information and assistance to understand potential Medi-Cal benefits.

Patient Information				
Patient name		Social Security number	Date of birth	
Home address		City	State	ZIP code
Home phone number	Cellphone number	Email address		

Preferred method of contact ☐ U.S. mail ☐ Email ☐ Home phone ☐ Cell phone	Annual household income: $_____
Marital status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic partner	Number of individuals in your household (as reported on your taxes): _____

Employment status
☐ Employed ☐ Self-employed ☐ Retired ☐ Disabled
☐ Unemployed – Last date worked: _____

Employer name	Phone number		
Employer address	City	State	ZIP code

Spouse/Domestic Partner/Parent/Guarantor Information		
Relationship to patient ☐ Spouse ☐ Domestic partner ☐ Parent ☐ Guarantor ☐ Other: _____		
Name	Social Security number	Date of birth

Employment status
☐ Employed ☐ Self-employed ☐ Retired ☐ Disabled
☐ Unemployed – Last date worked: _____

Employer name	Phone number		
Employer address	City	State	ZIP code

Insurance Coverage

Are you eligible for any health insurance coverage? ☐ **Yes** ☐ **No**
If "Yes," please provide the following:

Policyholder	Insurer	Policy number
Policyholder	Insurer	Policy number

Have you applied for Medi-Cal/Medicaid? ☐ **Yes** ☐ **No**
If "Yes," please describe the results of that application: _____

Have you been screened for Medi-Cal/Medicaid eligibility? ☐ **Yes** ☐ **No**
If "Yes," please describe the results of that screening: _____

Income & Expense Information			
Monthly Income (Current)	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Gross income	$	$	$
Monthly Essential Living Expenses	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Rent or mortgage	$	$	$
Real estate taxes	$	$	$
Home maintenance, cleaning and household supplies			
Utilities and telephone	$	$	$
Clothing and laundry			
Medical and dental			
Alimony/Child support	$	$	$
Transportation and auto (insurance, gas, repairs, lease)	$	$	$
Education	$	$	$
School/Childcare (minor dependents)	$	$	$
Food	$	$	$
Insurance	$	$	$
Other extraordinary expenses	$	$	$
Total monthly expenses	$	$	$

Medical Debt (Current)	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Outstanding medical debt at Cedars-Sinai or Huntington Health	$	$	$
Other medical debt	$	$	$

☐ Yes, I consent to the use of presumptive eligibility for the consideration of Charity Care or Discount Payment.

I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified by the Organization, and I authorize them to contact third-parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provided incorrect information or if the application contains a material error or omission, I will no longer be eligible for financial assistance. If financial assistance was previously granted to me, it may be reversed at that time, and I will be held responsible for the outstanding balance.

_____ _____

Signature of person applying for financial assistance Date

_____ _____

Signature of spouse/domestic partner/guarantor (if applicable) Date