SHARP

Financial Assistance Application

Please read this before filling out your application.

Sharp HealthCare offers financial help or discounted care to patients who qualify. This program helps people with low- income and no insurance, or high medical bills.

You can get **full financial assistance** if your **household income** is **at or below 400% of the Federal Poverty Level (FPL).**
To apply:

1. Fill out the attached Financial Assistance Application.
2. Attach proof of income, such as tax returns or pay stubs.
    - Tax returns: show your income for the year you were billed or the year before.
    - Paystubs: from within 6 months before or after you were first billed by the hospital.
    - For preservice requests, use pay stubs within 6 months of submitting the application.
3. **Send copies only – do not send original documents; they cannot be returned.**

Financial help may also be available for emergency room doctors or other providers that bill separately. Contact the billing office listed on your statement.

We will review your application and send you a written notice within 60 days of receiving it. While we review your application, your bill will be on hold until a decision is made.

If you have any questions or need help with this form or the Federal Poverty Level (FPL) chart, visit sharp.com/billing, or call 858-499-2400 (Monday -Friday, 8 a.m. - 4:30 p.m. PST).

For more information regarding current FPL guidelines, Medi-Cal, Covered California, or CMS visit:

- Federal Poverty Level Guidelines: detailed-guidelines-2025.pdf
- Covered California coveredca.com
- Medi-Cal dhcs.ca.gov/Pages/default.aspx
- Consumer Alliance: healthconsumer.org

- CMS sdcounty.ca.gov/hhsa/programs/ssp/county_medical_services

This form lets Sharp HealthCare employees use or share your protected health information only to review your financial assistance request. **You do not have to sign this form to receive medical care.**

Signing this form does not guarantee that you will qualify for financial help.

By signing, you allow Sharp HealthCare staff to use or share the information you provide to:

- Check if I qualify for financial assistance, or
- Chek if the hospital can receive financial help to cover part or all your care costs

You understand that the form needs to be filled out completely. You may still owe money for your hospital bill, if you do not qualify. The information that you provide on this form may only be released to:

- Pharmaceutical companies that may provide the free or low-cost replacement medications based on your financial situation.
- Charitable business, or government institutions who may offer financial help for medical costs.

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RETURN TO:
Sharp HealthCare
8695 Spectrum Center Blvd.
San Diego, CA 92123
Private Pay Unit/PFS-ICD *or*
Email to SPE.PFSFinancialAssistance@sharp.com
or
FAX to 858-636-2368

Guarantor ID(s)_____

_____

Total $ _____

PATIENT INFORMATION (PLEASE PRINT)

Patient Name _____ Phone # _____

Patient Social Security # _____ Guarantor ID # _____

Address _____

FAMILY INFORMATION: List any spouse, domestic partner, or children under the age of 21. If the patient is a minor, list all parents, caretakers, relatives, and siblings under the age of 21. Include any disabled person residing in the home.

Name	Age	Relationship

EMPLOYMENT INFORMATION

Employer (If self-employed, list business name): _____

Job Title: _____ Work Telephone: _____

Spouse (If self-employed, list business name): _____

Job Title: _____ Work Telephone: _____

CURRENT MONTHLY INCOME

	Patient	Other Family
Gross Pay **or** Business Income (if self-employed)	$_____	$_____
Interest and Dividends	$_____	$_____

CURRENT MONTHLY INCOME (CONTINUED)

Social Security	$_____	$_____
Other Income	$_____	$_____
Current Monthly Income	$_____	$_____
Total Current Monthly Income (Patient + Other Family)	$_____	

HOUSEHOLD AND INSURANCE INFORMATION

	Yes	No
Number of people living in household: _____		
Do you have health insurance? _____	☐	☐
Were your injuries caused by another person (for example, a car accident or fall)?	☐	☐
Do you have other insurance (such as auto insurance)? _____	☐	☐

ESSENTIAL LIVING EXPENSES

Write the amount or "N/A" if it does not apply.	
Rent or Mortgage *(circle one)*	$_____
Medical/Dental	$_____
Current Medical Payment(s)?	$_____
(Include copies of all paid, out-of-pocket medical bills for you or your family.	

By signing below, you agree to the following:

- I declare that everything I wrote on this form are true and correct.
- I will tell Sharp HealthCare within 10-days if there are any changes to my income, expenses, household, or address.
- If I receive care because of an accident or injury, I am to repay county, state, federal government or Sharp HealthCare from any settlement or lawsuit related to the event.
- I understand that if I do not qualify for financial help, I will be responsible for my bill.
- I may appeal the decision within 30- days of receiving the results. I can send more documentation in writing or schedule an in-person appointment with a business manager, chief financial officer.

- To schedule an appointment, call 858-499-2400, Monday-Friday, 8 a.m. to 4:30 p.m. (PST).
- After 30-days, I may need to submit a new application.
- I may revoke this authorization in writing at any time, following Sharp HealthCare's Privacy Policy.
- This authorization ends 90 days after Sharp receives this form.

Comments: _____

_____

_____

Patient Signature: _____ **Date:** _____

Spouse Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____