Scripps

How to Apply for Help with Medical Bills at Scripps

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

When you apply for help to pay for your medical care at Scripps, we will check two different programs. One is called Scripps 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 Scripps Charity Care program:

- For full help, your family must make 200% or less of the Federal Poverty Guidelines.

For Scripps Discount Payment program:

- If your family makes a little more money, between 201% and 400% of that guideline, you might get some help or discounts.

It is important to give Scripps 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 most recent Federal Tax return **OR** Copy of two most recent pay stubs dated from time of application
Self-employment	Copy of most recent Federal Tax return (including schedule C if applicable).
Social Security/ Retirement	Copy of most recent Federal Tax return **OR** Copy of award letter from Social Security stating monthly payment.
Disability	Copy of most recent Federal Tax return **OR** Copy of award letter stating disability payment
Unemployment	Copy of most recent Federal Tax return **OR** Copy of letter stating monthly award amount

STEP 2.

Provide a complete list of all potential payment sources to determine eligibility, including but not limited to:

- **Healthcare coverage** (e.g., private insurance, Medicare, Medi-Cal, or other government-funded programs)
- **Third-party liability coverage** (e.g., auto insurance, workers' compensation, or other liability policies)
- **International or travelers' insurance coverage** (e.g., coverage for visitors or non-U.S. residents)
- **Any other sources of financial support or coverage** (e.g., employer-sponsored programs, charitable assistance from other organizations, or other applicable policies).

Failure to disclose all payment sources may delay processing of your charity care application

STEP 3 **Fill out and sign the attached application.**

Need Help with the application? CALL Scripps Financial Assistance Department at (858) 927-5902, Monday through Friday, 8:00 am to 5:00pm

STEP 4. **Mail your application with all your paperwork to:**

Patient Financial Services Attn: Financial Assistance
Dept 10790 Rancho Bernardo Road 4S-303, San Diego, CA 92127
OR you can FAX your application and all your paperwork Fax: (858) 927-5041

Scripps

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)		Spouse/guardian Date of Birth (DOB) (mm/dd/yyyy)	
Spouse/guardian Home/mobile phone		Spouse/guardian Social Security #	

Will your spouse also be applying for financial assistance? c Yes c 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			

100-8560-019SW (Rev. 09/24/25)

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.

☐ Scripps Health can check my credit report and other sources to see if I qualify

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