Financial Assistance Application

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

FINANCIAL ASSISTANCE APPLICATION, INCLUDING LIST OF REQUIRED SUPPORTING DOCUMENTS

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 covers medically necessary care provided at Cedars-Sinai Medical Center, Cedars-Sinai Marina Hospital, Cedars-Sinai Medical Care Foundation ("CSMCF"), Huntington Hospital, Huntington Health Physicians as well as by faculty physicians in their capacity as faculty, CSMCF and Huntington Health physicians, including physicians employed by medical groups that have a professional services agreement with them, and the Cedars-Sinai emergency physicians. Patients scheduled as elective inpatients, non-emergent outpatients, or for follow-up care following discharge require prior approval for financial assistance by the Vice President, Finance and Chief Revenue Cycle Officer or their designee. Only medically necessary procedures are eligible for approval.

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 **pay stubs** (the two most recent) or **federal tax return** (prior year).
- 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.

A patient shall, as a condition of Charity Care, apply for coverage under Medi-Cal, Healthy Families and the County Trauma Program as applicable and, where appropriate, coverage under the Covered California. The foregoing shall also apply to patients residing out of state and their application for Medicaid within their state. Before receiving a Discount Payment, the Organization may request that the patient be screened for Medi-Cal eligibility, so that the patient receives information on Medi-Cal benefits. However, Medi-Cal enrollment will not be required to receive a Discount Payment

Patient Information		
Patient name	Social Security number	Date of birth

Cedars Sinai

Home address		City	State	ZIP code
Home phone number	Cellphone number	Email address		
Preferred method of contact ☐ U.S. mail ☐ Email ☐ Home phone ☐ Cellphone		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 agree to apply for any local, state and federal assistance for which I may be eligible to help alleviate the cost of any hospital and professional bills. 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