PATIENT

Name (first name, middle initial, last name)					Birth date (mm/dd/yyyy)				
Street address				City, State, ZIP					
Home/cell phone	Hospital Account N		umber Medical F		Record Number		Social Security number		
Spouse/guardian name (first name, middle initial, last name) Birth date (mm/dd/yyyy)									
Home/cell phone			Social Security number						
Will spouse also be applying for financial assistance? ☐ Yes ☐ No			Hospital Account Number Me			Medica	Medical Record Number		
FAMILY HOUSEHOLD/DEPE	ENDENTS	3	•			,			
Family Household Size:	(List	t the number	er of fami	ly membe	rs who live	with you	in your home, su	ch as a	
spouse, a qualified domestic	,			•		,	,		
a. Dependent name: (only if a				Birth da	late (mm/dd/yyyy)				
Relationship Ho.		Hospital A	lospital Account Number			Medical Record Number			
b. Dependent name: (only if applying for financial				assistance) Birth c			ite (mm/dd/yyyy)		
Relationship		Hospital A	ospital Account Number		Medical Record Number				
MONTHLY GROSS FAMILY	INCOME	(List ALL In	ncome fro	om family i	members in	the hou	sehold)		
MONTHLY GROSS FAMILY Applican		(List ALL In	ncome fro	om family ı		the house/guard			
	t/patient	\$	ncome fro			e/guard	ian	\$	
Applican Gross Salary/Wages (before Alimony/Child support	t/patient taxes)	\$	ncome fro	Gross Sa Alimony/0	Spous lary/Wages Child suppor	e/guard (before rt	ian taxes)	\$	
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FINANCIAL ASSISTANCE APPLICATION



Scripps Financial Assistance Program Step 1 QUALIFICATION REQUIREMENTS

Please read carefully before completing the application process.

Scripps offers assistance or discounted care to qualified patients. The following qualifications must be met: services must be medically necessary, gross income levels must be at or below 200% of Federal Poverty Guidelines for financial assistance, or between 201% - 400% for partial financial assistance/discount care. Applicant must complete and return the Financial Assistance Application with all supporting documents listed below within **14** days of receipt. Incomplete or missing information may result in a processing delay or denial of your application.

Step 2 INSTRUCTIONS

Provide the completed application and the applicable items from the list below:

- Letter explaining your current financial situation and how the balance(s) would create a financial hardship for you.
- Two months of recent bank statements (Checking, Savings, IRA, Money Markets etc.);
 please include all pages showing detailed transactions for each month.
- Proof of income. Choose the best option below that describes all income being received:
 - If employed: 30-days most recent pay-stubs showing current & YTD earnings/ deductions for patient and spouse (if married).
 - If self-employed and own your own business: Most recent two (2) years tax returns (form 1040 w/applicable Schedules) and YTD Profit & Loss Statement to support self-employed and/or commissioned income.
 - If currently unemployed/not working: Proof of "other" income (i.e. Social Security/ Disability, Unemployment, Retirement/Pension, etc.)
- If housing, food, or any other basic necessities are provided by another person, please have party submit letter explaining:
 - Relationship between patient and 3rd party,
 - What type of assistance is being provided
 - Frequency of assistance

Return Financial Assistance Application and supporting documents to:

Patient Financial Services Attn: Financial Assistance Dept 10790 Rancho Bernardo Road 4S-205 San Diego, Ca 92127

Phone: (858) 927-5902 Fax: (858) 927-5070

Email: financialassistancedept@scrippshealth.org

Questions? If you have any questions or if you need help with this application, please contact Scripps Financial Assistance Dept at 877-727-4777. Scripps Financial Assistance Department Office Hours are 8:00 AM to 4:30 PM.