Tri-City Medical Center

FINANCIAL ASSISTANCE FORM

Please read this before filling out your application.

Tri-City Medical Center provides financial assistance to eligible low-income patients, including uninsured individuals and insured patients with high medical costs who meet certain criteria.

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.
3. Send copies only – do not send original documents; they cannot be returned.

You may also qualify for financial assistance for services provided by other providers, such as emergency room doctors or specialists, who send their own separate bills. If you receive one, check your billing statement for their contact information.

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:
Call 760-940-7329 (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 Homepage
- Consumer Alliance: healthconsumer.org
- CMS sdcounty.ca.gov/hhsa/programs/ssp/county_medical_services

This form lets Tri-City Medical Center 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 Tri-City Medical Center staff to use or share the information you provide to:

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

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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.

RETURN TO:
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056
Patient Accounting

Medical Record or Encounter # ______________________

Total $ ______________________

PATIENT INFORMATION (PLEASE PRINT)

Patient Name ______________________	Phone # ______________________
Patient Social Security # ______________________	Medical Record or Encounter #
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	$	$
Social Security	$	$
Other Income	$	$
Current Monthly Income	$	$
Total Current Monthly Income (Patient + Other Family)	$	

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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 Tri-City Medical Center 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 to repay county, state, federal government or Tri-City Medical Center 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 business office staff, manager, or chief financial officer.
- To schedule an appointment, call 760-940-3179, 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 Tri-City Medical Center's Privacy Policy.
- This authorization ends 90 days after Tri-City receives this form.

Comments: ____

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Patient Signature: ______________________________ Date: ______________

Spouse Signature: ______________________________ Date: ______________

Parent/Guardian Signature: ______________________________ Date: ______________