CITY OF HOPE
FINANCIAL ASSISTANCE POLICY APPLICATION

As part of our commitment to serve the community, City of Hope provides financial assistance to patients who are in financial need and who satisfy certain requirements.

Individuals who are eligible to apply for public assistance, as well as individuals with the capacity to purchase health insurance, will be encouraged to do so as a means of assuring access to health care services.

To apply for Financial Assistance, please complete this form and provide the following documentation of income:

- ☐ Recent paystubs (within 6-month period before or after your first City of Hope bill), or
- ☐ Income tax return (for year in which you were first billed by City of Hope or 12 months prior to your first City of Hope bill)

Have you lived in the United States for more than 6 months within the last 12 months?

- ☐ Yes
- ☐ No (if you have not, we will connect you to our International Medicine Program)

The following documents are accepted **but not required**:

- IRS Form W-2 and Earnings Statement of all household earnings
- Governmental assistance, Social Security or Workers Compensation Eligibility
- Unemployment compensation letter
- Alimony payments received

There is no deadline by which you must apply for Financial Assistance. We will process your application upon receipt of recent pay stubs or income tax returns. If this documentation is not available, or if you need assistance completing this form, please contact Financial Clearance Services at 1500 E. Duarte Road, Duarte CA, 91010 or contact us by telephone at: (844) 936-4673. City of Hope may also use a presumptive eligibility tool to assess your eligibility for Financial Assistance.

Patient Name	_____	**Spouse Name**	_____
Address	_____		
	_____	**Phone**	_____

If you do not qualify for the Financial Assistance Program, which offers free care for qualifying individuals under 600% of the FPL, and your insurance does not cover your services at City of Hope, you may be eligible for a Self-Pay Discount. The Self-Pay Discount program provides less financial assistance than the Financial Assistance Program. To learn more, contact customer service by telephone at: (866) 268-4673.

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A: Family Status (List all dependents that you support; for minor patients include dependents supported by parent or guardian)

Name _____ Age _____ Relationship _____
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Total Family Size: _____

B: Current Monthly Income

	Guarantor	Spouse
1. Gross Pay from Employment		
2. Income from operating business (self-employed)		
3. Other Income (optional)		
a. Interest and dividends		
b. From rental property		
c. Social Security		
d. Unemployment		
e. Alimony		
TOTAL (Please Add)		

C: Deductions

	Guarantor	Spouse
1. Alimony, support payments paid		

D: Total Monthly Income

	Guarantor	Spouse
Total in box B less total in box C		

I/we affirm that all statements on this application are true to the best of my knowledge and belief.

_____
Signature of Patient or Guarantor Date

_____
Signature of Spouse/Domestic Partner Date