Rady Children's Hospital – San Diego
FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Instructions

The Rady Children's Hospital San Diego's Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs and are low-income, uninsured or underinsured, ineligible for a government program, and are otherwise unable to pay for medically necessary care based on their individual family financial situation.

To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information.

Please fully complete the attached application and return with copies of the following:

1. Documentation of Patient/Family income. Income may be verified through any 1 of the following mechanisms: 1.Tax returns (preferred) 2.Recent pay stubs/paycheck remittance or telephone verification by employment

    If the patient/Guarantor is unable to provide documentation of income, Rady Children's may in its sole discretion require the patient/Guarantor to make an attestation signed under the penalty of perjury as to (i) the truth of any income information provided on the Financial Assistance Application form, (ii) an explanation as to why they have not provided income documentation, and (iii) verification of the accuracy of Rady Children's calculation of their income.

2. Documentation of assets if (a) applying for Charity Care and (b) requested by Rady Children's.

3. If patient is insured and patient/guarantor is applying on basis of high medical expenses, documentation of medical expenses actually paid for the patient, including where applicable those medical expenses not incurred at Hospital in the prior 12 months. Expenses incurred by the guarantor, which are not related to the patient, will not be considered. Expenses must meet or exceed 10% of annual income prior 12 months.

4. Documentation of the *presence or absence* of third party health coverage (private insurance including coverage offered through the California Health Benefits Exchange, Medi-Cal, CCS, Tricare, Medicare, Worker's Compensation, automobile insurance, or other).
    a. All patient and/or guarantors applying for financial assistance are expected to pursue public health insurance options, including but not limited to Medi-Cal or California Children's Services, before RCHSD will make a final FAP eligibility determination.

Applications without income verification or signed attestation are considered incomplete and will not be processed. For assistance in completing this application, please contact Rady Children's Hospital – San Diego at 858-966-4005. Please return the application and verification of income documents within 21 calendar days by mail or in person to:

> Financial Counseling Department
> Rady Children's Hospital – San Diego
> 3020 Children's Way, MC 5055
> San Diego, California 92123-4282

We will notify you of your eligibility at the address provided on your financial assistance application.

PATIENT NAME   _____

GUARANTOR NAME   _____

GUARANTOR NAME   _____

ADDRESS   _____

_____

PHONE   _____

FAMILY STATUS: List all dependents in the household

Name	Age	Relationship
Total Dependents:		

EMPLOYMENT AND OCCUPATION

Guarantor Employer:_ _____   Position:_____

Contact Person and Telephone: _____

If Self-Employed, Name of Business: _____

Guarantor Employer:_____   Position:_____

Contact Person and Telephone: _____

If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

	Guarantor	Guarantor
Gross Pay (before deductions)	_____	_____
Add Income from Operating Business (if Self-employed)	_____	_____
Equals Current Monthly Income	_____	_____

Total Monthly Income (combine both Guarantors)   _____

By signing this form, I agree to allow Rady Children's Hospital – San Diego to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I am also required to provide the documents outlined in the RCHSD Financial Assistance Application Instructions **within 21 days**. I certify that all of the above is true and correct and that all income is reported. I understand that this information is being given for the determination of possible Financial Assistance for services rendered at Rady Children's Hospital San Diego; and that hospital officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to denial.

_____   _____

Signature of Guarantor   Date

_____   _____

Signature of Guarantor   Date