Guarantor Name: Guarantor Address: Guarantor Number: Patient Name: Date(s) of Service:	**UCI Health** **Financial Assistance / Screening Form**

Thank you for choosing UCI Health as your healthcare provider. Based upon our financial screening, you do not have any healthcare insurance to pay for your visit. UCI Health offers Financial Assistance/Charity Care for our uninsured and underinsured patients. Patients whose income is at or below 400% of the federal poverty level will be eligible for some kind of assistance. We are including our financial assistance/charity care application for your review.

All patients are encouraged to apply for Medi-Cal or any other assistance before charity care is considered.

To determine your eligibility for financial assistance, please complete this enclosed application and provide copies of the following list of documents to our office as soon as possible. You are financially responsible for the outstanding balance until your application is reviewed and approved or denied.

- ☐ Last 2 months paystubs or previous year or current year tax returns
- ☐ Proof of high medical cost (see below for explanation)
- ☐ Other: ____

If your balance represents your liability after your insurance has paid, you must provide proof of high-cost medical bills. High-cost medical bills means all medical liabilities you have paid in the last 12 months; that equals 10% or more of your annual household income.

If you have any questions or need assistance completing our financial assistance application, please contact our Single Billing Office at 833-353-7700 weekdays from 8:30 a.m. to 4:00 p.m.

You may submit your completed application and documents to UCImcbilling@uci.edu or upload via MyChart. To mail the application and documents, please send to:

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaint.hcai.ca.gov for more information and to file a complaint.

Help Paying Your Bill

There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to www.healthconsumer.org for more information.

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The UCI Health's Financial Assistance Program provides financial assistance to patients who receive medically necessary healthcare services who are low-income, uninsured, or underinsured, ineligible for a government program, or are otherwise unable to pay for medically necessary care based on their individual family financial situation.

To determine if a patient and/or guarantor qualifies for financial assistance, we need to obtain certain financial information. Your timely cooperation will allow us to review your application and quickly determine your eligibility for financial assistance. Please complete the questionnaire below and return it with copies of your pay stubs or tax returns.

Patient name: ....

UCI Health account # or guarantor #: ________________

Your name(s) and address (including country):

Phone numbers (circle best daytime number)

Home: .... Your work: ....

Date(s) of birth Yours: Your spouse's/guarantor:

Your employer or business (name and address)/ Your spouse's employer or business (name and address):

____

Age and relationship of family members or dependents who live with you and are claimed on your tax returns (dependents only):

____

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MONTHLY/ANNUAL INCOME

Please provide photocopies of two months paystubs.

	Monthly	**Annual**
Wages (self)	________________	________________
(spouse)	________________	________________
(Other family member)	________________	________________
Tax returns	________________	________________
TOTAL INCOME	$_______________	$_______________

- I declare the answers I have given are true and correct to the best of my knowledge.
- I agree to tell the provider of services, if there are any changes in my (or my family's) income, or in the persons in the household or of any change of address.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the hospital from proceeds from any litigation or settlement resulting from such act.
- I understand that if I do not qualify for financial assistance, I will be responsible for discounted charges related to services received, and eligible for payment arrangements. I may appeal the charity determination decision in writing with additional documentation.

Signature__________________________ Date __________

Spouse/Guarantor___________________ Date __________