

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. 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.
3. 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).

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 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: _____

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 Contact Person and Telephone: _____
 If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

	Guarantor	Guarantor
Gross Pay (before deductions)	_____	_____
<i>Add</i> Income from Operating Business (if Self-employed)	_____	_____
<i>Equals</i> 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. 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