FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Please return completed application and supporting documents to:

Cedars-Sinai Medical Center
Financial Assistance Processing Unit
File 1688
1801 W. Olympic Blvd, Pasadena, CA 91199-1688

Business Hours: 8 a.m. – 4:30 p.m.
Business Days: Monday - Friday
Phone Number: 323-866-8600
Email: Patient.Billing@cshs.org

Financial Assistance Application
Including List of Required Supporting Documents

This is the Organization's application for financial assistance. If you have any questions, the contact information is above.

We have two pathways for financial assistance. One is the usual pathway of applying for the maximum financial assistance ("Comprehensive Financial Assistance") that you might be eligible for under our Financial Assistance Policy (the "Policy"). The second pathway has abbreviated application requirements for patients seeking limited financial assistance ("Limited Financial Assistance").

To be considered for these financial assistance programs, please complete this application to help the Organization determine whether you may qualify to receive a discount. We cannot guarantee that you will qualify, even if you apply. A written response will be provided to all patients supporting approval/denial after we receive your completed application and documentation.

The Policy covers medically necessary care provided at Cedars-Sinai Medical Center, Cedars-Sinai Marina del Rey Hospital, Cedars-Sinai faculty physicians in their capacity as faculty, Cedars-Sinai Medical Care Foundation employed physicians or groups with an exclusive professional services agreement, Cedars-Sinai's emergency physicians of Community Urgent Care Medical Group, Inc., Huntington Hospital, and Huntington Health Physicians (the "Organization"). Elective/Cosmetic services and any other providers of service outside of the areas mentioned above may not be covered under this program.

You may submit the completed application by mail or email. Provide all documents requested below. Missing or unattached documents may cause a delay or denial of financial assistance. If unable to provide specific documents, please provide a letter of explanation.

FAILURE TO PROVIDE ALL REQUIRED INFORMATION MAY RESULT IN DENIAL.

PLEASE NOTE: IF YOU ARE UNINSURED AND MEET SPECIFIC MEDI-CAL PRESUMPTIVE ELIGIBILITY CRITERIA, YOU ARE NOT REQUIRED TO COMPLETE THIS APPLICATION.

Proof of Income Documents for Application **Documents to Provide:**	**Comprehensive Financial Assistance**	**Limited Financial Assistance**
Paycheck stubs (prior 2 months)	Required	Required
Federal Tax Return (prior year). See Footnotes 1 and 2 below.	Required	Required
Unemployment, social security or disability verification statements (prior two months)	Required	Optional
Bank statements for all checking, savings, and credit union accounts (prior two months and include all pages).	Required	Optional
Rent or mortgage verification.	Required	Optional
Medi-Cal application response letter (approval or denial), if applicable.	Required	Optional

1. If no federal tax return filed, provide most recent W2 or 1099 forms.
2. If federal tax return filing delayed due to temporary disability or unemployment, provide the non-

filing tax form. Obtain copies by calling 1-800-908-9946 or visiting www.irs.gov/individuals/get-transcript (use form 4506-T or 4506T-EZ).

Spouse/Partner Documents:

- If married, in a civil union, or domestic partnership, provide the applicable "Proof of Income" documents regarding your spouse/partner. See above list of documents, including but not limited to pay checks, verification statements, federal tax returns, W2 or 1099 forms, filing delay forms, bank statements and alimony/child support.

Completed Application:

- Completed application must include date and signature of the applicant.

Election for Limited or Comprehensive Financial Assistance

Applicants for limited financial assistance will only be eligible for financial assistance in an amount up to half of the amount that would be provided for the same service(s) under an application for full financial assistance.

FINANCIAL ASSISTANCE APPLICATION

Please check the type of financial assistance you are interested in applying for:

☐ Limited Financial Assistance (capped, ranging from 0% to 50%)
☐ Complete Financial Assistance (no cap, ranging from 0% to 100%)

PATIENT INFORMATION				
Patient Name		Social Security Number	Date of Birth	
Home Address		City	State	Zip Code
Home Number	Cell Number	Email Address		
Preferred Method of Contact ☐ US Mail ☐Email ☐Home Phone ☐ Cell Phone		Annual Household Income: $_____		
Marital Status: ☐Married ☐Single ☐Separated ☐ Divorced ☐Widowed ☐Domestic Partner		Number of Individuals in your Household (as reported on your taxes):		
Employment Status ☐ Employed ☐Self-employed ☐Retired ☐Disabled ☐ Unemployed - Last date worked: _____				
Employer Name		Phone Number		
Employer Address		City	State	Zip Code

SPOUSE/ DOMESTIC PARTNER/ PARENT/ GUARANTOR INFORMATION		
Relationship to Patient ☐ Spouse ☐Domestic Partner ☐Parent ☐Guarantor ☐Other: _____		
Name	Social Security Number	Date of Birth

Employment Status
☐ Employed ☐Self-employed ☐Retired ☐Disabled ☐Unemployed - Last date worked: _____

Employer Name	Phone Number		
Employer Address	City	State	Zip Code

INSURANCE COVERAGE

Are you eligible for any health insurance coverage? ☐ **Yes** ☐ **No** If yes, please provide following:

Policy Holder	Insurer	Policy Number
Policy Holder	Insurer	Policy Number

EXPENSE AND ASSET INFORMATION

Current Monthly Income	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Gross Pay	$	$	$
Net Self-Employed Income	$	$	$
Interest and Dividends	$	$	$
Real Estate or Rental Property	$	$	$
Social Security/Retirement/Disability	$	$	$
Alimony, Support Payments	$	$	$
Other	$	$	$
Total Monthly Income	$	$	$

Essential Living Expenses	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Rent or Mortgage	$	$	$
Real Estate Taxes	$	$	$
Utilities and Telephone	$	$	$
Alimony, Support Payment	$	$	$
Auto Loan/Lease Payment	$	$	$
Education	$	$	$
School/Childcare (Minor Dependents)	$	$	$
Food	$	$	$
Insurance	$	$	$
Other Expenses	$	$	$
Total Monthly Expenses	$	$	$

Current Medical Debt	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Outstanding Medical Debt (Cedars-Sinai)	$	$	$
Other Medical Debt	$	$	$

Assets (Exclude Retirement)	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Checking/Savings/Credit Union	$	$	$
Stocks and Bonds	$	$	$
Money Market/Brokerage	$	$	$
Certificates of Deposit	$	$	$
Total Assets	$	$	$

I certify that the information in this application is true and correct to the best of my knowledge. I agree to apply for any local, state, and federal assistance for which I may be eligible, to help alleviate the cost of any hospital and professional bills. I understand that the information provided may be verified by the Organization and I authorize them to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provided incorrect information or if the application contains a material error or omission, I will no longer be eligible for financial assistance. If financial assistance was previously granted to me, it may be reversed at that time, and I will be held responsible for the outstanding balance.

Signature of Person Applying for Financial Assistance _____ Date _____

Spouse/Domestic Partner/Guarantor Signature (if applicable) _____ Date _____