FINANCIAL ASSISTANCE APPLICATION
AND LIST OF REQUIRED SUPPORTING DOCUMENTS

Please return the completed application and supporting documents to:

Torrance Memorial Medical Center
Attn: Business Office
3330 Lomita Boulevard
Torrance, CA 90505
310-517-1010

This is Torrance Memorial Medical Center's ("TMMC") application for Charity Care or Discount Payment financial assistance. If you have any questions, the contact information is above.

To be considered, please complete this application to help TMMC determine whether you may qualify to receive Charity Care (free care) or a Discount Payment (reduced but not free care). Even if you apply, we cannot guarantee that you will qualify. 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 and applies to services provided by TMMC, as well as physicians who are required to participate as a condition of their contractual relationship with TMMC.

You may submit the completed, signed and dated application by mail.

- A completed application must include the date and signature of the applicant.
- There are no required deadlines for applying.
- In addition to the application, **provide proof of income documentation** for both you and your spouse/partner (if married, in a civil union or a domestic partnership). This documentation will be either:
    - **Recent tax returns** (These document a patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed.)
    - **Recent paystubs** (Within a 6-month period before or after the patient is first billed by TMMC or in the case of pre-service, when the application is submitted.)
- Missing or unattached documents may cause a delay or denial of financial assistance.

PLEASE NOTE: If you are uninsured and meet specific Medi-Cal presumptive eligibility criteria, you are not required to complete this application.

Patients will not be required to apply for or enroll in any insurance or benefit program, including Medi-Cal. However, TMMC may request a Medi-Cal eligibility screening (without requiring formal application) and will provide patients with information and assistance to understand potential Medi-Cal benefits.

Patient Information

Patient name		Social Security number	Date of birth	
Home address		City	State	ZIP code
Home phone number	Cellphone number	Email address		

Preferred method of contact
☐ U.S. mail ☐ Email ☐ Home phone ☐ Cellphone

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 the following:

Policyholder	Insurer	Policy number
Policyholder	Insurer	Policy number

Have you applied for Medi-Cal/Medicaid? ☐ **Yes** ☐ **No**
If "Yes," please describe the results of that application: _____

Have you been screened for Medi-Cal/Medicaid eligibility? ☐ **Yes** ☐ **No**
If "Yes," please describe the results of that screening: _____

Income & Expense Information			
Monthly Income (Current)	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Gross income	$	$	$

Monthly Essential Living Expenses	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Rent or mortgage	$	$	$
Real estate taxes	$	$	$
Home maintenance, cleaning and household supplies			
Utilities and telephone	$	$	$
Clothing and laundry			
Medical and dental			
Alimony/Child support	$	$	$
Transportation and auto (insurance, gas, repairs, lease)	$	$	$
Education	$	$	$
School/Childcare (minor dependents)	$	$	$
Food	$	$	$
Insurance	$	$	$
Other extraordinary expenses	$	$	$
Total monthly expenses	$	$	$

Medical Debt (Current)	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Outstanding medical debt at Cedars-Sinai or Huntington Health	$	$	$
Other medical debt	$	$	$

☐ Yes, I consent to the use of presumptive eligibility for the consideration of Charity Care or Discount Payment.

I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified by TMMC, 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

_____ _____

Signature of spouse/domestic partner/guarantor (if applicable) Date