Patient Label

UCI Health

Financial Assistance / Charity 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 must apply for Medi-Cal before charity care funds are 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 two pay stubs (including year to date earnings)
- ☐ Proof of child support / alimony income/payment (if applicable).
- ☐ Proof of disability / unemployment income (if applicable).
- ☐ Notarized statement of in-kind support
- ☐ Last two years of signed income tax returns including forms, if self employed
- ☐ Approval or denial letter from Medi-Cal
- ☐ Last two months of complete bank statements
- ☐ Proof of high medical cost (see below for explanation)
- ☐ Other: ________________________________

<u>If your balance represents your liability after your insurance has paid</u>, 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:

Single Billing Office
1500 S. Douglass Road., Suite-200
Anaheim, CA 92806

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The UCI Health's Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs 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/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, bank statements and additional documents.

Patient name:____

UCI Health account/guarantor # __________________________

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

Phone numbers (circle best daytime number)

Home: Your work:
Your spouse's work:

Social Security numbers Yours: Your spouse's/guarantor:

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 people who live with you and are claimed on your tax returns (dependents only):

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Bank Accounts (include Checking, Savings, Credit Unions, Retirement, etc.):

Institution Name	Address	Account Type	Account #	Balance
a)				
b)				
c)				

Real estate:

Address (including country)	Current Value	Loan Balance	Payment Amount
a)			
b)			
c)			

Motor vehicles:

Year and Make, License #	Current Value	Loan Balance	Payment Amount
a)			
b)			
c)			

Additional Information (expected changes in income, health, etc.)

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MONTHLY/ANNUAL INCOME

PLEASE PROVIDE TWO MONTHS OF PHOTOCOPIES OF PAY-STUBS AND BANK STATEMENTS AND LISTED INCOME

	Monthly	Annual
Wages (self)		______
(spouse)	______	______
(Other family member)	______	______
Self-employment	______	______
Public Assistance	______	______
Social Security	______	______
Unemployment Compensation	______	______
Retirement	______	______
Alimony /Child Support	______	______
Military Family Allotments	______	______
Pensions	______	______
Dividends, Interest, Rent, Income	______	______
TOTAL INCOME	______	______

MONTHLY EXPENSES

(Expenses must be reasonable for the family size, location, and unique circumstances)

	Monthly
Rent	______
Mortgage	______
Alimony/Child Support	______
Food/Groceries	______
Utilities	______
a) Electricity	______
b) Heating/Natural Gas	______
c) Water	______
d) Telephone	______
Transportation	______
Medical (self-pay)	______
Insurance	
a) Auto	______
b) Health	______
c) Life	______
d) Homeowners/Renters	______
Estimated tax payments	______
TOTAL EXPENSES	$______

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I hereby authorize UCI Health to inquire into my credit history through a credit reporting agency toverify the information I have provided.
- I agree to tell the provider of services, within 10 days, if there are any changes in my (or my family's) income, property, expenses, or in the persons in the household or of any change of addresses.
- 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 uncompensated services, I will be personally liable for the charges of the services rendered by UCI Health, or I may appeal the charity determination decision in writing with additional documentation.

Signature_________________________________Date _______________

Spouse/Guarantor___________________________Date _______________