Financial Assistance Application

FINANCIAL ASSISTANCE

Please return completed application and supporting financial documents to:

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

Business Hours: 8 a.m. – 5 p.m., weekdays
Phone Number: 323-866-8600 File 1688
24-Hour Access by Fax: 323-866-3077
Email: Patient.Billing@cshs.org

Financial Assistance Required Supporting Financial Documents

Please provide the financial documents requested below. If any documents are missing or are not attached, your application will be delayed or denied. If you are unable to provide specific documents, please provide a letter of explanation.

Primary Documents:

- Proof of income and non-wage income (as described above)
  - Prior two months of Employer Checks or Stubs
  - Prior two months of Unemployment, Social Security or Disability verification statements, etc.
- Federal Tax Return
  - If you did not file a Federal tax return, include your most recent W2 or 1099
  - If you are unable to provide your tax return information due to delay in tax filing, temporary disability, or unemployment, please provide your non-filing tax form. You can obtain a copy by calling 1-800-908-9946 or visit www.irs.gov/individuals/get-transcript (use form 4506-T or 4506T-EZ)
- Prior two months of Bank Statements for all Checking, Savings, and Credit Union accounts (please include all pages)
- Rent or Mortgage verification

Supplemental/Other Documents:

- Proof of Non-Wage Income:
  - Statement of Alimony income
  - Statement of Business income
  - Statement of Child Support income
- If Married or in a Civil Union: Provide the following applicable documents regarding your spouse/partner
  - Proof of income and non-wage income (as described above)
  - Federal Tax return
    - If you did not file Federal tax return, include your most recent W2 or 1099
    - If you are unable to provide your tax return information due to delay in tax filing, temporary disability, or unemployment, please provide your non-filing tax form. You can obtain a copy by calling 1-800-908-9946 or visit www.irs.gov/individuals/get-transcript (use form 4506-T or 4506T-EZ)
  - Prior two months of your most recent statement for all checking, savings, and credit union accounts

Completed Application:

- Completed application with date and signature

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	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 ☐ 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
Name of Health Insurance (offered by employer including COBRA) ☐ Health Insurance not provided			

INSURANCE COVERAGE

1. Are you eligible for any health insurance coverage?

☐ Health Insurance	☐ Yes	☐ No
☐ Medicare	☐ Yes	☐ No
☐ Medi-Cal	☐ Yes	☐ No
☐ Veterans Administration	☐ Yes	☐ No
☐ Foreign Policy	☐ Yes	☐ No

If yes, please provide the following information.

Policy Holder	Insurer	Policy Number
Policy Holder	Insurer	Policy Number

Cedars Sinai

SCREENING QUESTIONS
1. Is the treatment provided related to any of the following? ☐ Accident ☐Crime ☐Workplace injury ☐Other:
2. Have you hired an attorney or are you pursuing a claim for your injury or illness? a. If yes, please provide: Attorney Name ______ Attorney Phone Number ______
3. Have you already applied for Medi-Cal? (We may ask that you do so) ☐ Yes - Awaiting Approval ☐Yes - Ineligible ☐No a. If no, please check all that apply below: ☐ You are 19 years or younger ☐ You are 65 years or older ☐ You are blind ☐ You are taking medication to control diabetes, high blood pressure, or seizures ☐ You are disabled as determined by the Social Security Administration ☐ You are pregnant ☐ You have children under the age of 19 living with you

EXPENSE AND ASSET INFORMATION

Current Monthly Income	**Patient**	**Spouse**	**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	Spouse	Total
Rent or Mortgage	$	$	$
Real Estate Taxes	$	$	$
Utilities and Telephone	$	$	$

FINANCIAL ASSISTANCE APPLICATION			
Essential Living Expenses	**Patient**	**Spouse**	**Total**
Alimony, Support Payment	$	$	$
Auto Loan/Lease Payment	$	$	$
Education	$	$	$
School/Childcare (Minor Dependents)	$	$	$
Food	$	$	$
Insurance	$	$	$
Other Expenses	$	$	$
Total Monthly Expenses	$	$	$
Current Medical Debt	**Patient**	**Spouse**	**Total**
Outstanding Medical Debt (Cedars-Sinai)	$	$	$
Other Medical Debt	$	$	$
Assets (Exclude Retirement Accounts)	**Patient**	**Spouse**	**Total**
Checking/Savings/Credit Union Accounts	$	$	$
Stocks and Bonds	$	$	$
Money Market/Brokerage Accounts	$	$	$
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 Cedars-Sinai Medical Center and/or Marina Del Rey Hospital, and I authorize CSMC/MDRH 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 (when applicable) — Date