Cedars Sinai

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

Business Hours: 8 a.m. – 6 p.m., weekdays
Phone Number: 323-866-8600
24-Hour Access by Fax: 323-866-3077
Email: Patient.Billing@cshs.org

It is possible the services you received may be eligible for coverage under Cedars-Sinai's Financial Assistance Policy. In order to properly assess your ability to pay all or part of the hospital bill(s) under the Cedars-Sinai Financial Assistance Policy, however, additional documentation is required.

Attached for your review is a policy summary. To assist us in our evaluation, please submit the following documentation no later than 15 days from the date of this letter. Please note that it is imperative to include all requested documents or provide a signed statement explaining why any of the items **below** do not pertain to your situation. Please return your information by the mail, fax or email information noted at the top of this letter**. We ask that you send copies of the documents referenced below as they will not be returned to you:**

(1) Fully completed application (enclosed with this letter).
- A copy of your current Federal Tax Return (example, Form 1040) or prior year's filings along with the attached 4506-T form, signed and dated. Do not send your state tax return. If a Federal Tax Return is not available, include a copy of your most recent pay stub(s) from all employment during the last six (6) months (patient and spouse) and let us know if there is a significant change in your prior year's income.
- Please note that this includes public assistance, for example, Unemployment, Disability Payments, Social Security, etc.
- If you are not receiving any income that would be reflected in the documents listed above, please prepare a brief statement stating your current financial situation. Be sure to sign and date the statement.
- If you are receiving financial assistance from someone, please have that person submit a written statement stating the amount and frequency of financial assistance being provided to you.

(2) Rent or Mortgage verification (coupon, rental receipt, canceled check)
- If you are living with someone, please have that person submit a written statement explaining the financial terms of the arrangement.

(3) Copy of your prior two (2) month's checking and savings bank statements (all pages for patient and for the spouse).

(4) Copy of Money Market/Brokerage account statements, Stock & Bond certificates and Certificate of Deposits, if applicable.

Retirement accounts such as 401(k) and 403(b) statements and pension plans are excluded and should not be provided.

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Please also understand that submission of a complete application does not mean that your services will qualify under the Cedars-Sinai Financial Assistance Policy. There are a number of considerations involved in our review. Once the review process is complete, you will be notified by mail of the outcome of your application.

Cedars-Sinai's Financial Assistance Policy provides assistance for patients whose family income does not exceed 600 percent of the Federal Poverty Level. There are a number of other federal, state, local and private sources available to fund care to low-income individuals. We can help you identify funding sources that would apply to your situation.

Should you have any questions, please contact the Customer Service Representatives at 323-866-8600 for assistance.

Sincerely,

CSMC Department of Patient Financial Services

Cedars Sinai

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name:_____

Patient Account or Medical Record Number:_____

Date of Birth:_____ Last 4 Digits of SS#: XXX-XX-_____

Best Daytime Telephone Number: ( )_____-_____

Address:_____

City:_____State:_____ Zip:_____

Spouse's Name:_____Last 4 Digits of SS#: XXX-XX-_____

Are you a U.S. Citizen? Yes No

If not, a resident alien? Yes No

If not, a non-resident alien? Yes No

Family Status: List all dependents that you support (if more than 4 use separate page)

Name	Age	Relationship

Employment and Occupation

Employer:_____Position:_____

If self-employed, name of business:_____

Employer address:_____

Phone: ( )_____-_____ How long employed:_____

Spouse's Employer:_____Position:_____

If self-employed, name of business:_____

Current Monthly Income	**Patient**	**Spouse**	**Total**
Gross Pay (Salary)	$	$	$
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	$	$	$
Alimony, Support Payment	$	$	$
Auto Loan/Lease Payment	$	$	$
Education	$	$	$
School/Childcare (Minor Dependents)	$	$	$
Food	$	$	$
Insurance (Home/Auto)	$	$	$
Other Expenses	$	$	$
Total Monthly Expenses	$	$	$

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

Assets (Exclude Retirement Accounts)	Patient	Spouse	Total
Stocks and Bonds	$	$	$
Money Market/Brokerage Accounts	$	$	$
Certificates of Deposit	$	$	$
Total Assets	$	$	$

By signing this application, I agree to allow Cedars-Sinai to check my employment and request a credit history.

_____ _____

(Signature of Patient) (Date)

_____ _____

(Signature of Spouse) (Date)