FINANCIAL ASSISTANCE APPLICATION

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 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 the Organization 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 at Cedars-Sinai Medical Center, Cedars-Sinai Marina Hospital, Cedars-Sinai Medical Care Foundation ("CSMCF"), Huntington Hospital, Huntington Health Physicians, as well as by faculty physicians in their capacity as faculty, CSMCF and Huntington Health physicians including physicians employed by medical groups that have a professional services agreement with them, and the Cedars-Sinai emergency physicians. Patients scheduled as elective inpatients, non-emergent outpatients, or for follow-up care following discharge require prior approval for financial assistance by the Vice President, Finance and Chief Revenue Cycle Officer or their designee. Only medically necessary procedures are eligible for approval.

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

- 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 domestic partnership). This documentation will be either **pay stubs** (the two most recent) or **federal tax return** (prior year).
- 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.

A patient shall, as a condition of Charity Care, apply for coverage under Medi-Cal, Healthy Families, and the County Trauma Program as applicable and, where appropriate, coverage under Covered California. The foregoing shall also apply to patients residing out of state and their application for Medicaid within their state. Before receiving a Discount Payment, the Organization may request that the patient be screened for Medi-Cal eligibility, so that the patient receives information on Medi-Cal benefits. However, Medi-Cal enrollment will not be required to receive a Discount Payment.

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Cedars Sinai

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Patient Information

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

Preferred method of contact
☐ U.S. 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

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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

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 (Cedars-Sinai or Huntington Health)	$	$	$
Other medical debt	$	$	$

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☐ 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 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 _____

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