Keck Hospital of USC
Keck Medicine of USC

USC Norris Cancer Hospital
Keck Medicine of USC

USC Verdugo Hills Hospital
Keck Medicine of USC

Keck Medical Center of USC (KMC), which includes Keck Hospital of USC, USC Norris Cancer Hospital, and Verdugo Hills Hospital (VHH), is dedicated to providing quality health care to our patients. We realize that payment for services many be a financial hardship for you at this time. KMC offers Financial Assistance to aid those that may qualify to reduce or eliminate their cost of care obligation.

Attached with this letter, you will find an application to enable an evaluation of your financial hardship. You must complete the application in order to be considered for the financial assistance program. If your financial situation meets the eligibility criteria set forth by the KMC's Financial Assistance Program, you may be eligible for full or partial forgiveness of debt.

In order to process this application we require:

- The enclosed application completed in its entirety.
- You must sign and date the financial assistance application. If the patient/guarantor and/or spouse provide information, both must sign the application.
- Copy of your most recent cancelled rent check, lease agreement or mortgage payment.
- Copy of the last two (2) pay stubs for any wage earned contributing to the household income.
- Copy of bank statements (checking/savings).
- Copy of your disability, social security payment statement, unemployment notice of eligible benefits and bank statement reflecting deposits.
- If you do not have a source of income or proof of income documents, please provide a letter explaining how you support yourself and your family. This is a written and signed statement from a family member or friend who is providing your room and board and/or income.
- Copy of your most recent 1040 tax return or W2, including all applicable schedules and attachments submitted to the Internal Revenue Service.
- If your most recent 1040 tax return is not available, then we will need one of the following:
    - Social Security Awards Letter
    - Proof of non-filing from the IRS (call 800-829-1040 to obtain a copy)
    - A signed letter explaining why you have not filed a federal tax return or have requested an extension for taxes.
- Attach an additional page if you need more space to answer any questions.

We realized that your income from previous tax records may not adequately reflect your current circumstances. If so, please attach a brief note that describes your current financial situation. It is important that you complete and submit the completed Financial Assistance Application along with all the required documents within fifteen (15) days.

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Please send your Financial Assistance Application and Documents to:

Keck Hospital and Norris Cancer Hospital:

- Contact the Financial Assistance Coordinator
- Call: Keck 866-860-8964
  Norris 866-763-7429
- Secure Fax for both Facilities: 201.419.7409
- Mail: Keck Hospital of USC/Norris Cancer Hospital
  PO Box 864
  Mahwah, NJ 07430-0864

Verdugo Hills Hospital (VHH):

- Contact the Financial Assistance Coordinator
- Call: 818-949-4055
- Secure Fax: 818-949-4006
- Mail: Verdugo Hills Hospital (VHH)
  1812 Verdugo Blvd
  Glendale Ca 91208

Once we have reviewed your application, we will notify you of our decision in writing as soon as possible. If you wish to discuss your account or have any questions, please contact Patient financial Services at:

Keck 866-860-8964
Norris 866-763-7429
Verdugo Hills 818-949-4055

Our business hours are Monday – Friday, 8:30 am to 4:30 pm.

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FINANCIAL ASSISTANCE APPLICATION

Demographic Information

Name	Date of Birth	Spouse/Partner	Date of Birth	
Address		**City**	**State**	**Zip**
Time at Present Address **_____Rent ____Own ____Years ____Months**		**County**	**Marital Status** **__Married __Single __Divorced __Widowed**	
Cell Number	**Work Number**	**Home Number**	**Spouse Cell Number**	**Spouse Work Number**

Please list ALL persons living in your household; including dependents (Attached an additional sheet if needed)

Last Name	First Name	MI	Date of Birth	Relationship to Applicant
1				
2				
3				
4				

Self		**Spouse**	
Social Security#		**Social Security#**	
Employed By		**Employed By**	
Business Address		**Business Address**	
Occupation		**Occupation**	
Length Employed **__Years __Months** **__Hours worked per week**		**Length Employed** **__Years __Months** **__Hours worked per week**	

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Income: Represents total cash receipts from all sources before taxes.

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	Self Monthly Gross		Spouse Monthly Gross	
	Gross Income		Gross Income	
	Social Security/SSI/SSDI		Social Security/SSI/SSDI	
	Public Assistance		Public Assistance	
	Rental Property Income		Rental Property Income	
	Work Comp		Work Comp	
	Unemployment		Unemployment	
	Child Support		Child Support	
	Other		Other	
	TOTAL		**TOTAL**	

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Assets/Property					
Checking		Cash on Hand			
Savings		Trust Account			
Stock/Bonds		Credit Union		Other	

Monthly Expense			
House Payment/Rent	Auto Insurance	Life Insurance	Health Insurance
Property Tax	Phone/Cell Phone	Food	Water and Sewer
Property Insurance	Vehicle Payment	Daycare Expense	Medical Expenses
Gas	Vehicle Payment	Child Support Expense	Other/Specify:
Electric			**TOTAL**

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Required Documents:

_ Proof of Income (i.e. 2 Pay stubs for each wage earner, SS, SSI, SSDI, Public Assistance, Rental Income, Retirement, Pension, VA Benefits, Unemployment, Workers Comp, Child Support, Alimony, or Other)
_ Copy of your most recent 1040 tax return, including all applicable schedules and attachments
_ Copy of two (2) bank statements (checking/savings) all pages.
_ Copy of your most recent cancelled rent check, lease agreement or mortgage payment
_ Written statement from a family member or friend who is proving your room and board and/or income.
_ Complete Financial Assistance Application

ASSIGNMENT OF RIGHTS

By signing below, I declare under penalty of perjury that the information and statements contained in this Application for Financial Assistance and all documentation which I submit are accurate true and correct. You are hereby authorized to check my credit history in order to evaluate this application for Financial Assistance consideration.

I understand that Keck Medical Center of USC may make reasonable requests for additional information and verification if necessary.
I understand that the information and statements I have provided will be kept confidential by Keck Medical Center of USC.
I understand that the completion of the application will allow Keck Medical Center of USC to consider my circumstances.
I understand Keck Medical Center of USC makes no representation that financial assistance is guaranteed.

I/We hereby certify the above information and voluntarily authorize you to obtain credit information relative to me/us.

Signature Date Signature Date