FINANCIAL ASSISTANCE APPLICATION



Scripps Financial Assistance Program Step 1 QUALIFICATION REQUIREMENTS

Please read carefully before completing the application process.

Scripps offers assistance or discounted care to qualified patients. The following qualifications must be met: services must be medically necessary, gross income levels must be at or below 200% of Federal Poverty Guidelines for financial assistance, or between 201% - 400% for partial financial assistance/discount care. Applicant must complete and return the Financial Assistance Application with all supporting documents listed below within **14** days of receipt. Incomplete or missing information may result in a processing delay or denial of your application.

Step 2 INSTRUCTIONS

Provide the completed application and the applicable items from the list below:

(<u>Do not</u> send copies of original documents, they will not be returned.)

- Letter explaining your current financial situation and how the balance(s) would create a financial hardship for you.
- Two months of recent bank statements (Checking, Savings, IRA, Money Markets etc.); please include all pages showing detailed transactions for each month.
- Proof of income. Choose the best option below that describes all income being received:
 - If employed: 30-days most recent pay-stubs showing current & YTD earnings/ deductions for patient and spouse (if married).
 - If self-employed and own your own business: Most recent two (2) years tax returns (form 1040 w/applicable Schedules) and YTD Profit & Loss Statement to support self-employed and/or commissioned income.
 - If currently unemployed/not working: Proof of "other" income (i.e. Social Security/ Disability, Unemployment, Retirement/Pension, etc.)
- If housing, food, or any other basic necessities are provided by another person, please have party submit letter explaining:
 - Relationship between patient and 3rd party,
 - What type of assistance is being provided
 - Frequency of assistance

Return Financial Assistance Application and supporting documents to:

Patient Financial Services Attn: Financial Assistance Dept 10790 Rancho Bernardo Road 4S-303 San Diego, Ca 92127

Fax: (858) 927-5000

Email: financialassistancedept@scrippshealth.org

Questions? If you have any questions or if you need help with this application, please contact Scripps Financial Assistance Dept at (858) 927-5902, Monday through Friday, 9:00am to 4:30pm PDT.

PATIENT

Name (first name, middle initial, last name)					Birth date (mm/dd/yyyy)				
Street address				City, State, ZIP					
Home/cell phone	Hospital Account N		umber Medical F		Record Number		Social Security number		
Spouse/guardian name (first name, middle initial, last name) Birth date (mm/dd/yyy						⁄уууу)			
Home/cell phone			Social Security number						
Will spouse also be applying for financial assistance? ☐ Yes ☐ No			Hospital Account Number Me		Medica	Medical Record Number			
FAMILY HOUSEHOLD/DEPE	NDENTS	3				'			
Family Household Size:	(List	t the number	er of fami	lv membe	rs who live	with you	in your home, su	ch as a	
	Family Household Size: (List the number of family members who live with you in your home, such as a spouse, a qualified domestic partner, and children under the age of 18.)								
a. Dependent name: (only if a					Birth da	date (mm/dd/yyyy)			
Relationship Ho		Hospital A	Hospital Account Number			Medical Record Number			
b. Dependent name: (only if applying for financial				assistance) Birth c			ate (mm/dd/yyyy)		
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