

# Financial Assistance Application Instructions

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](mailto:Patient.Billing@cshs.org)

## **Financial Assistance Application** **Including List of Required** **Supporting Documents**

This is the Organization’s application for financial assistance. If you have any questions, the contact information is above.

We have two pathways for financial assistance. One is the usual pathway of applying for the maximum financial assistance (“Comprehensive Financial Assistance”) that you might be eligible for under our Financial Assistance Policy (the “Policy”). The second pathway has abbreviated application requirements for patients seeking limited financial assistance (“Limited Financial Assistance”).

To be considered for these financial assistance programs, please complete this application to help the Organization determine whether you may qualify to receive a discount. We cannot guarantee that you will qualify, even if you apply. 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 del Rey Hospital, Cedars-Sinai faculty physicians in their capacity as faculty, Cedars-Sinai Medical Care Foundation employed physicians or groups with an exclusive professional services agreement, Cedars-Sinai’s emergency physicians of Community Urgent Care Medical Group, Inc., Huntington Hospital, and Huntington Health Physicians (the “Organization”). Elective/Cosmetic services and any other providers of service outside of the areas mentioned above may not be covered under this program.

You may submit the completed application by mail or email. Provide all documents requested below. Missing or unattached documents may cause a delay or denial of financial assistance. If unable to provide specific documents, please provide a letter of explanation.

**FAILURE TO PROVIDE ALL REQUIRED INFORMATION MAY RESULT IN DENIAL.**

**PLEASE NOTE: IF YOU ARE UNINSURED AND MEET SPECIFIC MEDICAL PRESUMPTIVE ELIGIBILITY CRITERIA, YOU ARE NOT REQUIRED TO COMPLETE THIS APPLICATION.**

<b>Proof of Income Documents for Application</b>	<b>Comprehensive Financial Assistance</b>	<b>Limited Financial Assistance</b>
<b>Documents to Provide:</b>		
Paycheck stubs (prior 2 months)	Required	Required
Federal Tax Return (prior year). See Footnotes 1 and 2 below.	Required	Required
Unemployment, social security or disability verification statements (prior two months)	Required	Optional
Bank statements for all checking, savings, and credit union accounts (prior two months and include all pages).	Required	Optional
Rent or mortgage verification.	Required	Optional
Medi-Cal application response letter (approval or denial), if applicable.	Required	Optional

1. If no federal tax return filed, provide most recent W2 or 1099 forms.

2. If federal tax return filing delayed due to temporary disability or unemployment, provide the non-filing tax form. Obtain copies by calling 1-800-908-9946 or visiting [www.irs.gov/individuals/get-transcript](http://www.irs.gov/individuals/get-transcript) (use form 4506-T or 4506T-EZ).

### **Spouse/Partner Documents:**

- If married, in a civil union, or domestic partnership, provide the applicable "Proof of Income" documents regarding your spouse/partner. See above list of documents, including but not limited to pay checks, verification statements, federal tax returns, W2 or 1099 forms, filing delay forms, bank statements and alimony/child support.

### **Completed Application:**

- Completed application must include date and signature of the applicant.

### **Election for Limited or Comprehensive Financial Assistance**

Applicants for limited financial assistance will only be eligible for financial

assistance in an amount up to half of the amount that would be provided for the same service(s) under an application for full financial assistance.

## Financial Assistance Application

**Please check the type of financial assistance you are interested in applying for:**

- Limited Financial Assistance (capped, ranging from 0% to 50%)  
 Complete Financial Assistance (no cap, ranging from 0% to 100%)

PATIENT INFORMATION				
Patient Name		Social Security Number		Date of Birth
Home Address		City		State e
Home Number	Cell Number	Email Address		
Preferred Method of Contact <input type="checkbox"/> US Mail <input type="checkbox"/> Email <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone			Annual Household Income: \$ _____	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner			Number of Individuals in your Household (as reported on your taxes):	
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed - Last date worked: _____				
Employer Name			Phone Number	
Employer Address			City	State e
SPOUSE/ DOMESTIC PARTNER/ PARENT/ GUARANTOR INFORMATION				
Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Parent <input type="checkbox"/> <input type="checkbox"/> Guarantor <input type="checkbox"/> Other: _____				
Name		Social Security Number		Date of Birth
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed - Last date worked: _____				
Employer Name			Phone Number	
Employer Address			City	State    Zip Code

**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

**EXPENSE AND ASSET  
INFORMATION**

<b>Current Monthly Income</b>	<b>Patient/ Guarantor</b>	<b>Spouse/ Partner</b>	<b>Total</b>
Gross Pay	\$	\$	\$
Net Self-Employed Income	\$	\$	\$
Interest and Dividends	\$	\$	\$
Real Estate or Rental Property	\$	\$	\$
Social Security/Retirement/Disability	\$	\$	\$
Alimony, Support Payments	\$	\$	\$
Other	\$	\$	\$
<b>Total Monthly Income</b>	\$	\$	\$

<b>Essential Living Expenses</b>	<b>Patient/ Guarantor</b>	<b>Spouse/ Partner</b>	<b>Total</b>
Rent or Mortgage	\$	\$	\$
Real Estate Taxes	\$	\$	\$
Utilities and Telephone	\$	\$	\$
Alimony, Support Payment	\$	\$	\$
Auto Loan/Lease Payment	\$	\$	\$
Education	\$	\$	\$
School/Childcare (Minor Dependents)	\$	\$	\$
Food	\$	\$	\$
Insurance	\$	\$	\$
Other Expenses	\$	\$	\$
<b>Total Monthly Expenses</b>	\$	\$	\$

<b>Current Medical Debt</b>	<b>Patient/ Guarantor</b>	<b>Spouse/ Partner</b>	<b>Total</b>
Outstanding Medical Debt (Cedars-Sinai)	\$	\$	\$

Other Medical Debt	\$	\$	\$
<b>Assets (Exclude Retirement)</b>			
	<b>Patient/ Guarantor</b>	<b>Spouse/ Partner</b>	<b>Total</b>
Checking/Savings/Credit Union	\$	\$	\$
Stocks and Bonds	\$	\$	\$
Money Market/Brokerage	\$	\$	\$
Certificates of Deposit	\$	\$	\$
<b>Total Assets</b>	\$	\$	\$

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

---

Spouse/Domestic Partner/Guarantor Signature (if applicable)

---

Date