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. All applicable funding sources must be complied with and a determination made based on full cooperation. These funding options include County Medical Services (CMS), Medi-Cal, California Victim Compensation Program, etc. Applicant must complete and return the attached Financial Assistance Application with all supporting documents listed below within **14** days of receipt.

Step 2
INSTRUCTIONS

Please provide the applicable items from the list below for review. (***Please send copies of original documents, as 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. ***Please 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

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.

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Step 3

Please be sure to fill out the application as completely as you can. Any missing information may delay any financial assistance you may receive. Incomplete information will result in a delay in processing or denial of your application.

PATIENT

Name (first name, middle initial, last name)			Birth date (mm/dd/yyyy)
Street address			City, State, ZIP
Home/cell phone	Hospital Account Number	Medical Record Number	Social Security number
Spouse/guardian name (first name, middle initial, last name)			Birth date (mm/dd/yyyy)
Home/cell phone		Social Security number	
Will spouse also be applying for financial assist☐ce? ☐ Yes No		Hospital Account Number	Medical Record Number

FAMILY HOUSEHOLD/DEPENDENTS

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 applying for financial assistance)		Birth date (mm/dd/yyyy)
Relationship	Hospital Account Number	Medical Record Number
b. Dependent name: (only if applying for financial assistance)		Birth date (mm/dd/yyyy)
Relationship	Hospital Account Number	Medical Record Number

MONTHLY GROSS FAMILY INCOME (List ALL Income from family members in the household)

Applicant/patient		**Spouse/guardian**	
Gross Salary/Wages (before taxes)	$	Gross Salary/Wages (before taxes)	$
Alimony/Child support	$	Alimony/Child support	$
Self-employment or Business income*	$	Self-employment or Business income*	$
Pension or retirement/Annuities	$	Pension or retirement/Annuities	$
Unemployment benefits	$	Unemployment benefits	$
Social Security/state disability/temporary disability/ supplemental security	$	Social Security/state disability/temporary disability/ supplemental security	$

income/veterans benefits		income/veterans benefits	
Rental property	$	Rental property	$
Other, including cash income (describe):	$	Other, including cash income (describe):	$
Total monthly income	**$**	**Total monthly income**	**$**

FINANCIAL AGREEMENT AND CREDIT REPORT AUTHORIZATION

I hereby declare under penalty of perjury that all information set forth above in this application is true and accurate in all respects, and that all attachments are accurate copies of the original documents. I also acknowledge and agree that I am liable to Scripps Health for any and all amounts owing to Scripps Health for medical goods and services that are not covered by the Program.

- ☐ Scripps Health retains the right to obtain information from consumer credit reporting agencies and other third-party information sources to determine my eligibility.

Applicant or account holder will be notified, by mail, whether the application is approved or denied.

Signature of Patient/Guarant or **X**	Date (mm/dd/yyyy)
Signature of Spouse of Patient/Guarantor **X**	Date (mm/dd/yyyy)