***Please read carefully before completing the application process.***

Sharp HealthCare offers financial assistance, discounted care or charity care to qualified patients (low-income uninsured patients and low-income insured patients with high medical costs that meet specific criteria). The following qualifications must be met: Services must be emergent and 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. Applications denied for lack of cooperation will not be considered for financial assistance. Applicant must complete and return the attached Financial Assistance Application with all supporting documents listed below within 10-days of receipt.

Financial assistance is also available from the emergency room physicians and other providers (that bill separately). Please contact the physicians billing office for information on their financial assistance program at the number listed on their billing statement.

Supporting documents include (Please send copies of original documents, as they will not be returned.):

- Three months of income verification (all forms required):
  - ~ All bank statements for the last three (3) months
  - ~ Pay-stubs or other proof of income for the last three (3) months
  - ~ Income tax return filing for most recent year (ex: 1040 form)
  - ~ Annual Profit and Loss form (schedule C), for self-employed.
- If applicable, include copy of denial letter from county or state financial assistance program, such as CMS, or Medi-Cal.
- Copies of all paid annual out-of-pocket medical bills paid by the patient or patient's family in the prior 12 months.
- Students over 18 years of age who live independently should provide their own information including proof of school enrollment.
- Students over 18 years of age, that are dependents, may provide an affidavit of support from supporting third party and provide proof of school enrollment, as well as all previous applicable documents.

Sharp HealthCare or its agents may ask for additional information to support your application and eligibility for financial assistance. All information may be subject to verification, including, but not limited to contact with your employer, bank, credit verification, and property searches in and out of the United States.

We will notify you with the results in writing within 60 days of receipt. Until a financial determination is made, your visit will remain with Sharp HealthCare. If you have any questions regarding the Financial Assistance Application, please contact us online at http://www.sharp.com/billing, or call Monday through Friday between 8:00 a.m. – 4:30 p.m. (PST) at (858) 499-2400.

| Persons in Family Unit | Department of Health and Human Services 2023 Poverty Guideline (200%) | 400% of Federal Poverty Guidelines |
|---|---|---|
| 1 | $29,160.00/yr. or $2,430.00/mo. | $58,320.00/yr. or $4,860.00/mo. |
| 2 | $39,440.00/yr. or $3,287.00/mo. | $78,880.00/yr. or $6,573.00/mo. |
| 3 | $49,720.00/yr. or $4,143.00/mo. | $99,440.00/yr. or $8,287.00/mo. |
| 4 | $60,000.00/yr. or $5,000.00/mo. | $120,000.00/yr. or $10,000.00/mo. |
| 5 | $70,280.00/yr. or $5,857.00/mo. | $140,560.00/yr. or $11,713.00/mo. |
| Each Additional Person | $10,280.00/yr. | $20,560.00/yr. |

For more information regarding Federal Poverty Guidelines, Medi-Cal, Covered California, or CMS visit:
Federal Poverty Guidelines https://www.federalregister.gov Covered California https://www.coveredca.com
Medi-Cal http://www.dhcs.ca.gov/Pages/default.aspx Consumer Alliance https://consumerhealth.org
CMS www.sdcounty.ca.gov/hhsa/programs/ssp/county_medical_services

# FINANCIAL ASSISTANCE APPLICATION

RETURN TO:
Sharp HealthCare
8695 Spectrum Center Blvd.
San Diego, CA 92123
Private Pay Unit/PFS-ICD
Or
Email to SPE.PFSFinancialAssistance@sharp.com
FAX to: (858) 636-2368

Visit Number(s)
#_____
#_____

Total $_____

This form authorizes the use of disclosure of protected health information in the manner described below and is voluntary. Sharp HealthCare cannot withhold treatment from you solely because of your refusal to complete this form. Completion of this form does not guarantee that you will be eligible for or will receive financial assistance.

As provided by federal law, I authorize the employees or agents of Sharp HealthCare to use or disclose the information provided by me on or with this form to determine if I am eligible for financial assistance or if the hospital is eligible for financial assistance to cover some or all of the cost of my care. I understand that the form needs to be filled out completely. I further understand that I may remain responsible for my hospital bill, whether or not I receive assistance, unless I am eligible for Financial Assistance. The information that I provide on this form may only be released as needed to:

1) Pharmaceutical companies that may offer the hospital free or low-cost replacement medications based on my financial status.
2) Other specific charitable, business or government institutions who may offer health-related financial assistance programs.

## I. Patient Information (please print)

Name_____
Address_____
City, State, Zip_____
Employer_____
Occupation_____

Social Security #_____
Date of Birth_____
Home #_____
Work #_____
Has the patient been declared permanently disabled?
☐ Yes ☐ No

## II. Spouse Information (or Parent if Patient is less than 18 years old)

Name_____
Address_____
City, State, Zip_____
Employer_____
Occupation_____

Social Security #_____
Date of Birth_____
Home #_____
Work #_____

## III. Other Parent (if Patient is less than 18 years old)

Name_____
Address_____
City, State, Zip_____
Employer_____
Occupation_____

Social Security #_____
Date of Birth_____
Home #_____
Work #_____

## IV. List all Persons Living in the Patient's Home (or Parent[s] Home if Patient is less than 18 years old)

| NAME | RELATIONSHIP | AGE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## V. Monthly Income

Patient Wages *_____

Spouse Wages *_____

Parent Wages *_____

(If patient less than18 yrs.)

Social Security *_____

Non-deferred Pension *_____

Disability *_____

Unemployment *_____

Alimony/Child Support ****_____

Interest *_____

Rental

Other _____

**TOTAL** _____

## VI. Essential Living Expenses

Rent/Mortgage (circle one) _____

Maintenance Expenses _____

Alimony/Child Support**** _____

Food/Supplies _____

Utilities/Telephone _____

Clothing _____

Medical/Dental _____

Insurance _____

Car/Transportation _____

School or Child Care _____

Installment/Revolving _____

Current Medical Payment(s): _____

Fuel & Repairs _____

Laundry/Cleaning _____

Other _____

**TOTAL** _____

## VII. Assets

Cash on Hand _____

Real Estate in U.S. or Abroad:

Address_____Value_____Equity_____

Address_____Value_____Equity_____

Business Value _____

Other _____

**TOTAL** _____

## VIII. Other Assets

Checking Account #/Institution **Bal_____

Savings Account #/Institution **Bal_____

Vehicle 1 (Year/Make/Model/Value) _____

Vehicle 2 (Year/Make/Model/Value) _____

RV/Boat/Motorcycle/Motorhome:

(Year/Make/Model/Value) _____

**TOTAL** _____

**Include pay stubs or other proof of income for the last three (3) months.*

***Include last three (3) bank statements.*

****Include copies of all paid, annual out-of-pocket medical bills paid by the patient or patient's family.*

*****Provide supporting documentation such as judgments, agreements, liens, etc.*

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.

- I agree to tell the provider of service within 10-days if there are any changes in the income, property, expenses, household, or address.

- I understand that I may be asked to prove my statements and that my eligibility will be subject to verification including, but not limited to: contact with my employer, bank, credit verification, and property searches in and out of the United States.

- I further agree that in consideration for receiving health care services because of accident or injury, I agree to reimburse the county, state, federal government or hospital from the proceeds of any litigation or settlement resulting in such act.

- I understand that if I do not qualify for financial assistance, I will be personally liable for the charges of the service rendered by Sharp HealthCare. I may appeal the decision within 30-days of receiving the application results with additional documentation in writing or schedule an in-person appointment with a business manager, chief financial officer, or other appropriate manager. To schedule an appointment, call Customer Service, Monday through Friday, 8 a.m.–4:30 p.m. (PST) at (858) 499-2400. After 30-days a new application may be required to review your appeal.

- The undersigned authorizes Sharp HealthCare to obtain a credit report in order to help determine the eligibility of the patient for financial assistance. It is understood that this information may be shared with third parties as described in this form.

- I understand that once my information leaves Sharp HealthCare, Sharp is no longer able to control or protect my information directly, and I release Sharp HealthCare from any liability that may arise from the release of my information to the types of companies or institutions listed above.

- I understand this authorization may be revoked in writing at any time, according to the instructions in the Sharp HealthCare Notice of Privacy Practices, except to the extent that action has been taken in reliance on this authorization.

This authorization shall end for this Financial Assistance Application, 90 days from the receipt date.

**Comments**_____

_____

**Patient Signature**_____ **Date**_____

**Spouse Signature**_____ **Date**_____

**Parent/Guardian**_____ **Date**_____