

Please read carefully before completing the application process.

Sharp HealthCare offers financial assistance or charity care to qualified patients (low-income uninsured patients and low-income insured patients with high medical costs that meet specific criteria). Gross income levels must be at or below 400% for full financial assistance/charity care. The applicant should complete and return the attached Financial Assistance Application with supporting income documentation. Required supporting documentation includes the last two (2) months: Pay-stubs, Income tax return filing for most recent year (ex: 1040 form), or Annual Profit and Loss form (Schedule C), for self-employed, or other proof of income. **Please send copies of original documents, as they will not be returned.**

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.

We will notify you with the results in writing within 60-days of receipt. Until a financial determination is made, your visit will remain on hold pending determination. If you have any questions regarding the Financial Assistance Application or you need assistance obtaining the current year's Federal Poverty Level (FPL) scale please contact us online at sharp.com/billing, or call Monday through Friday between 8 a.m. to 4:30 p.m. (PST) at 858-499-2400. For more information regarding, current FPL guidelines, Medi-Cal, Covered California, or CMS visit:

FPL Guidelines: [detailed-guidelines-2025.pdf](#)

Covered California coveredca.com

Medi-Cal dhcs.ca.gov/Pages/default.aspx

Consumer Alliance: healthconsumer.org

CMS sdcounty.ca.gov/hhsa/programs/ssp/county_medical_services

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 program.



Application for Financial Assistance Consideration

RETURN TO:

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

Guarantor ID(s) _____

Total \$ _____

PATIENT INFORMATION (PLEASE PRINT)

Patient Name _____ Phone # _____

Patient Social Security # _____ Guarantor ID # _____

Address _____

FAMILY STATUS: List any spouse, domestic partner, or children under the age of 21. If the patient is a minor, list all parents, caretakers, relatives, and siblings under the age of 21. Regardless of age, list any disabled person residing in the home.

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT INFORMATION

Employer (If self-employed, list business name): _____

Job Title: _____ Work Telephone: _____

Spouse (If self-employed, list business name): : _____

Job Title: : _____ Work Telephone: _____

CURRENT MONTHLY INCOME

	Patient	Other Family
Gross Pay (if employed) or Gross Income from Business Operations (if self-employed)	\$ _____	\$ _____
Interest and Dividends	\$ _____	\$ _____
Social Security	\$ _____	\$ _____
Other Income / Profit and Loss Statement Amount	\$ _____	\$ _____

Other (Specify):	\$ _____	\$ _____
Current Monthly Income	\$ _____	\$ _____
Total Current Monthly Income (Patient + Other Family)	\$ _____	

HOUSEHOLD AND INSURANCE INFORMATION

	Yes	No
Total number of family members living in household: _____		
Do you have health insurance? _____	<input type="checkbox"/>	<input type="checkbox"/>
Were your injuries caused by a third party (such as during a car accident or slip and fall)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have other insurance that may apply (such as an auto policy)? _____	<input type="checkbox"/>	<input type="checkbox"/>

ESSENTIAL LIVING EXPENSES

Write the amount (if not applicable, write "N/A")	
Rent or Mortgage (<i>circle one</i>)	\$ _____
Medical/Dental**	\$ _____
Current Medical Payment(s)?	\$ _____
**Include copies of all paid, annual out-of-pocket medical bills paid by the patient or patient's family.	

- 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, expenses, household, or address.
- 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. to 4:30 p.m. (PST) at 858-499-2400. After 30-days a new application may be required to review your appeal.



Application for Financial Assistance Consideration

- 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 Signature: _____	Date: _____