

Please read this before filling out your application.

Sharp HealthCare provides **financial assistance** to eligible low-income patients, including uninsured individuals and insured patients with high medical costs who meet certain criteria.

To apply:

1. Fill out the attached Financial Assistance Application.
2. Attach proof of income, such as tax returns or pay stubs.
 - Tax returns: show your income for the year you were billed or the year before.
 - Paystubs: from within 6 months before or after you were first billed by the hospital.
3. **Send copies only – do not send original documents; they cannot be returned.**

You may also qualify for financial assistance for services provided by other providers, such as emergency room doctors or specialists, who send their own separate bills. If you receive one, check your billing statement for their contact information.

We will review your application and send you a written notice within 60 days of receiving it. While we review your application, your bill will be on hold until a decision is made.

If you have any questions or need help with this form, call 858-499-2400 (Monday -Friday, 8 a.m. 4:30 p.m. PST).

For more information regarding current FPL guidelines, Medi-Cal, Covered California, or CMS visit:

- Federal Poverty Level 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 lets Sharp HealthCare employees use or share your protected health information only to review your financial assistance request. **You do not have to sign this form to receive medical care.**

Signing this form does not guarantee that you will qualify for financial help.

By signing, you allow Sharp HealthCare staff to use or share the information you provide to:

- Check if I qualify for financial assistance, or
- Check if the hospital can receive financial help to cover part or all your care costs

You understand that the form needs to be filled out completely. You may still owe money for your hospital bill, if you do not qualify. The information that you provide on this form may only be released to:

- Pharmaceutical companies that may provide the free or low-cost replacement medications based on your financial situation
- Charitable business, or government institutions who may offer financial help for medical costs.



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 or
 FAX to 858-636-2368

Guarantor ID(s) _____

 Total \$ _____

PATIENT INFORMATION (PLEASE PRINT)

Patient Name _____ Phone # _____
 Patient Social Security # _____ Guarantor ID # _____
 Address _____

FAMILY INFORMATION: 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. Include 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 or Business Income (if self-employed)	\$ _____	\$ _____
Interest and Dividends	\$ _____	\$ _____
Social Security	\$ _____	\$ _____

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

HOUSEHOLD AND INSURANCE INFORMATION

	Yes	No
Number of people living in household: _____		
Do you have health insurance? _____	<input type="checkbox"/>	<input type="checkbox"/>
Were your injuries caused by another person (for example, a car accident or fall)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have other insurance (such as auto insurance)? _____	<input type="checkbox"/>	<input type="checkbox"/>

ESSENTIAL LIVING EXPENSES

Write the amount or "N/A" if it does not apply.	
Rent or Mortgage (<i>circle one</i>)	\$ _____
Medical/Dental	\$ _____
Current Medical Payment(s)?	\$ _____
(Include copies of all paid, out-of-pocket medical bills for you or your family.)	

By signing below, you agree to the following:

- I declare that everything I wrote on this form are true and correct.
- I will tell Sharp HealthCare within 10-days if there are any changes to my income, expenses, household, or address.
- If I receive care because of an accident or injury, I to repay county, state, federal government or Sharp HealthCare from any settlement or lawsuit related to the event.
- I understand that if I do not qualify for financial help, I will be responsible for my bill.
- I may appeal the decision within 30- days of receiving the results. I can send more documentation in writing or schedule an in-person appointment with business office staff, manager, or chief financial officer.
- To schedule an appointment, call 858-499-2400, Monday- Friday, 8 a.m. to 4:30

p.m. (PST).

- After 30-days , I may need to submit a new application.
- I may revoke this authorization in writing at any time, following Sharp HealthCare’s Privacy Policy.
- This authorization ends 90 days after Sharp receives this form.

Comments: _____

Patient Signature: _____

Date: _____

Spouse Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____