# Application for Financial Assistance Consideration

***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 http://www.sharp.com/billing, or call Monday through Friday between 8:00 a.m. – 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 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

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.

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

Guarantor ID(s) _____

Total $ _____

**PATIENT INFORMATION (PLEASE PRINT)**

Patient Name _____ Patient SS# _____
Phone _____ Guarantor ID# _____
Address _____

FAMILY STATUS: List any spouse, domestic partner, or children under the age of 21. If patient is a minor, list all parents, caretaker, relatives, and siblings under 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 OR Income from Operating Business for Self-Employed | $ | $ |
| Other Income / Profit and Loss Statement Amount | $ | $ |
| Interest and Dividends | $ | $ |
| Social Security | $ | $ |
| Other (Specify): | $ | $ |
| Current Monthly Income | $ | $ |
| Total Current Monthly Income (Patient + Spouse) | $ | |

SHARP

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## FAMILY SIZE

| | Yes | No |
|---|---|---|
| Total number of family members living in household _____ | | |
| Do you have health insurance? _____ | ☐ | ☐ |
| Were your injuries caused by a third party (such as during a car accident or slip and fall)? | ☐ | ☐ |
| Do you have other insurance that may apply (such as an auto policy)? _____ | ☐ | ☐ |

## ESSENTIAL LIVING EXPENSES

| Write the amount (if not applicable, write "N/A") |
|---|
| Rent or Mortgage (circle one) _____ |
| 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.–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**_____