

***Please read this before filling out your application.***

Sharp HealthCare offers financial help or discounted care to patients who qualify. This program helps people with low- income and no insurance, or high medical bills.

You can get **full financial assistance** if your **household income** is **at or below 400% of the Federal Poverty Level (FPL)**.

To apply:

1. Fill out the below 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.
  - For preservice requests, use pay stubs within 6 months of submitting the application.
3. **Send copies only – do not send original documents; they cannot be returned.**

Financial help may also be available for emergency room doctors or other providers that bill separately. Contact the billing office listed on your statement.

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 or the Federal Poverty Level (FPL) chart, visit [sharp.com/billing](https://sharp.com/billing), or call 760-940-7329 (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](https://coveredca.com)
- Medi-Cal [dhcs.ca.gov/Pages/default.aspx](https://dhcs.ca.gov/Pages/default.aspx)
- Consumer Alliance: [healthconsumer.org](https://healthconsumer.org)

- CMS [sdcounty.ca.gov/hhsa/programs/ssp/county\\_medical\\_services](https://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 Tri City Medical Center

4002 Vista Way

Oceanside, CA 92056

Attn: Patient Accounting

Email to [STCCorrespondence@sharp.com](mailto:STCCorrespondence@sharp.com)

or

FAX to 760-940-3572

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 <b>or</b> Business Income (if self-employed) | \$ _____ | \$ _____     |
| Interest and Dividends                                 | \$ _____ | \$ _____     |

## CURRENT MONTHLY INCOME (CONTINUED)

|                                                       |          |          |
|-------------------------------------------------------|----------|----------|
| 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 am to repay county, state, federal government or Sharp HealthCare Center 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 a business manager, chief financial officer.
- To schedule an appointment, call 760-940-7329, 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-Tri-City Medical Center receives this form.

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Spouse Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_