USCArcadia
Hospital
Keck Medicine of USC

APPENDIX C

FINANCIAL ASSISTANCE PROGRAM APPLICATION

The following is the Financial Assistance Program Application. This application, policy and other related information are also available translated into the following written languages: Mandarin (Standard Chinese); and Spanish.

USC Arcadia Hospital (USCAH) offers Financial Assistance to aid those that may qualify to reduce or eliminate their cost of care obligation. Attached you will find an application to enable an evaluation of your financial hardship. You must complete the application in order to be considered for the financial assistance program and you must apply within six months of when you received the services you are applying for.

Applying for the Financial Assistance Program

You must meet the following criteria to be eligible for the Financial Assistance Program:

Types of Care: You must be receiving medically necessary services.

Other Payer Sources: We recommend that you apply for any private or public sector sources of medical financial assistance for which you are eligible, such as Medi-Cal or Healthy Families. You may be required to submit documentation of your application (or of the approval or denial of your application) to those sources. For services received which are the result of an accident you must show proof that there was no settlement before financial assistance can be considered.

Income: Your household income must be at or below 400 percent of the Federal Poverty Guidelines (FPG). If your financial situation meets the eligibility criteria set forth by the USCAH's Financial Assistance Program, you may be eligible for full or partial forgiveness of debt.

Federal Poverty Guideline 2023					
Percent Discount		100%	75%	50%	25%
Household/ Family Size	100%	200%	267%	335%	400%
1	$ 14,580	$ 29,160	$ 38,929	$ 48,843	$ 58,320
2	$ 19,720	$ 39,440	$ 52,652	$ 66,062	$ 78,880
3	$ 24,860	$ 49,720	$ 66,376	$ 83,281	$ 99,440
4	$ 30,000	$ 60,000	$ 80,100	$ 100,500	$ 120,000
5	$ 35,140	$ 70,280	$ 93,824	$ 117,719	$ 140,560
6	$ 40,280	$ 80,560	$ 107,548	$ 134,938	$ 161,120
7	$ 45,420	$ 90,840	$ 121,271	$ 152,157	$ 181,680
8	$ 50,560	$ 101,120	$ 134,995	$ 169,376	$ 202,240

Special Circumstances: If you have unusually high medical costs or you've experienced a catastrophic event, you may be eligible for the Financial Assistance Program under special circumstances, regardless of whether you meet the household income requirements described above. To qualify, you'll need to provide income documentation and copies of your out-of-pocket medical expenses for the past 12 months indicating that these expenses equal 10 percent or more of your annual gross income. Please note: Not all medical expenses qualify for financial assistance. Exclusions include, but are not limited to, expenses for premiums and dues, optical and hearing aids, medical supplies, health education classes, transportation, over-the-counter drugs and lifestyle medications (fertility, cosmetic, etc.).

Documentation required: In order to process this application, we require the following documents:

- The enclosed application is completed in its entirety.
- You must sign and date the financial assistance application. If the patient/guarantor and/or spouse provide information, both must sign the application.
- Copy of your most recent cancelled rent check, lease agreement or mortgage payment.
- Copy of the last two pay stubs for any wage earned contributing to the household income.
- Copy of your two most current bank statements (checking/savings).
- Copy of your disability, social security payment statement, unemployment notice of eligible benefits and bank statement reflecting deposits.
- If you do not have a source of income or proof of income documents, please provide a letter explaining how you support yourself and your family. This is a written and signed statement from a family member or friend who is providing your room and board and/or income.
- Copy of your most recent tax return, including all applicable schedules and attachments submitted to the Internal Revenue Service. If your most recent tax return is not available, then we will need one of the following:
    - Social Security Awards Letter.
    - Proof of non-filing from the IRS (call 800-829-1040 to obtain a copy).
    - If you have not filed a current federal tax return and have requested an extension for taxes, please include the previous year's tax returns.

Be sure to send only photocopies as originals will not be returned to you. You'll have an opportunity to appeal the decision if your application is denied. Corrected and/or additional documentation will be required to support your appeal request. Upon finalization of your application, notification of your determination will be mailed to the address on file.

Please send your Financial Assistance Application and required documents:

- Mail: USC Arcadia Hospital, Attention: Business Office – Financial Assistance Program, 300 West Huntington Drive, Arcadia, CA 91066-6016
- Secure Fax: 626-821-6917
- Email: Carol.Mcclary@med.usc.edu

If you have any questions, please contact the Customer Service Representative at 626-574-3594. Once we have reviewed your application, we will notify you of our decision in writing as soon as possible. Our business hours are Monday – Friday, 8:00 am to 5:00 pm PST

FINANCIAL ASSISTANCE APPLICATION

Patient Name:____ Account # ____________________
Patient Guarantor (Responsible Party Information)
Name:____ Relationship to Patient: ________________
Address: _____________________________________ City: ________________ State: _____ Zip: __________
Marital Status: **M** (Married), **S** (Single), **D** (Divorced), **W** (Widowed): ______________

	Self	**Spouse**
Social Security #		
Date of Birth		
Employed By		
Employer Address		
Occupation		

Please list ALL persons living in your household: including dependents (attach additional sheet if needed):

	Last Name	**First Name**	**MI**	**Date of Birth**	**Relationship to Applicant**
1.					
2.					
3.					
4.					
5.					

Please list all sources of annual income:

	Self	**Spouse**
Gross Income		
Social Security/SSI/SSDI		
Pension Income		
Public Assistance		
Rental Property Income		
Self Employed Income		
Unemployment Support		
Workers Compensation Payments		
Child Support		
Other		
Total		

Please list all assets (market value of items you or your spouse own)

Checking Accounts	$	Home Value	$
Savings Accounts	$	Other Real Estate Value	$
Trust Accounts	$	Business Owned	$
Investment Accounts	$	Franchise	$
Other accounts	$	Other Major Assets	$

Medical Expenses

If your household income exceeds 400percent of the Federal Poverty Guidelines (FPG) or if you are applying for special circumstances, you must complete this section.

Please provide copies of receipts and/or itemized invoices for out-of-pocket medical expenses due or paid in the last 12 months

	Patient Responsibility after Insurance Payment		**Patient Responsibility after Insurance Payment**
Hospital Visits	$	Other Expenses (Describe)	$
Doctor Visits	$		$
Prescribed medications	$		$
Skilled Nursing Care	$		$

Medi-Cal Screening

Have you applied for Medi-Cal or other governmental Assistance? (yes or no) ___________________

If the answer to the above question is yes, please provide the approval, denial or pending letter from Medi-Cal or other governmental agency.

Financial Agreement and credit report authorization

I hereby declare under penalty of perjury that all information set forth above in this application is true and accurate in all respects, and that all attachments are accurate copies of the original documents. I authorize employees and agents of USC Arcadia Hospital (USCAH) to investigate and verify that the information I have provided to it, including employment and credit history for the purpose of determining my eligibility to participate in the Financial Assistance Program. I also acknowledge and agree that I am liable to USCAH for any and all amounts owing to USCAH for medical goods and services that are not covered by the Financial Assistance Program (the remaining amounts).

Signature of Applicant/Guardian____ Date: _____________

Signature of Spouse of Applicant: ____ Date: _____________