Patient Financial Services
Financial Assistance Dept
10150 Sorrento Valley Road, Suite 300
San Diego, CA 92121
Tel: (858) 587-4493
Fax: (858) 657-4205

Date:

Name
Address
City, State, Zip Code

Patient Name:
Account Number:
Date of Service:

Current Balance Due:

Dear Patient:

You have requested financial assistance for the above referenced account. Please complete the attached application and provide the applicable items from the list below for review to determine if you qualify for a discount through our financial assistance program.

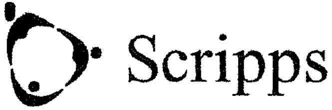
- Complete Patient Financial Assessment Statement (application); see attached.
- Letter from the patient explaining your current financial situation and how paying the balance would create a financial hardship for you.
- Proof of income:
    - 30-days most recent pay-stubs showing current and YTD earnings & deductions for the patient and spouse (if married).
    - Most recent two (2) years tax returns (form 1040 w/applicable Schedules) **and** YTD Profit & Loss Statement to support self-employed and/or commissioned income.
    - Proof of "other" income (i.e. SSI/Disability, Unemployment, Retirement, Pension, etc.).
- Most recent two (2) months bank statements for all bank accounts (i.e. Checking, Savings, IRA, Money Markets, etc.) for which you are a signer. Provide all pages showing account holder's information (i.e. name, address, etc.) and detailed transactions for each month.
- Letter from the person(s) providing the patient with housing, food and other basic necessities, if applicable. The letter must state the relationship between the patient and 3rd party as well as what type of assistance is being provided.

Please mail the completed application and supporting documentation within ten (10) business days of receipt of this letter using the enclosed envelope; fax to (858) 657-4205, Attn: Financial Assistance Dept. or send via email to FinancialAssistanceDept@scrippshealth.org.

If you have any further questions, please contact Scripps Financial Assistance Dept @ (858) 587-4493, Monday through Friday, 9:00am to 4:30PM PDT.

Sincerely,

Financial Assistance Dept



PATIENT FINANCIAL ASSESSMENT STATEMENT

RESPONSIBLE PARTY NAME: LAST	FIRST	MIDDLE
PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY		ACCOUNT/MEDICAL RECORD #:
SPOUSE		NUMBER OF DEPENDENTS
STREET ADDRESS		HOME PHONE ( )
CITY, STATE & ZIP		WORK PHONE ( )
OCCUPATION	EMPLOYER (IF SELF EMPLOYED, DESCRIPTION)	
SOCIAL SECURITY #	ADDRESS	
YEARS AT EMPLOYER	SALARY____________ ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY OTHER INCOME: ______________SOURCE____________	

SPOUSE

OCCUPATION	EMPLOYER (IF SELF EMPLOYED, DESCRIPTION)	
SOCIAL SECURITY #	ADDRESS	
PHONE	YEARS AT EMPLOYER	SALARY ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY
OTHER INCOME	SOURCE	

ASSETS		**LIABILITIES /** MONTHLY TOTALS	
CASH ON HAND	$__________	MORTGAGE/RENT PAYMENT	$__________
CHECKING ACCOUNT*	$__________	INSURANCE PREMIUMS:	
SAVINGS ACCOUNT*	$__________	☐ AUTO, ☐ MEDICAL, ☐ HOME	$__________
CREDIT UNION ACCOUNT*	$__________	OTHER:__________	
REAL ESTATE EQUITY	$__________	UTILITIES: ☐ GAS, ☐ ELECT., ☐ WATER, ☐ PHONE	$__________
MOTOR VEHICLES OWNED	$__________	AUTO PAYMENTS	$__________
MAKE/YEAR__________	VALUE __________	FOOD	$__________
MAKE/YEAR__________	VALUE __________	OTHER LIABILITIES:	
TRUST ACCOUNTS	$__________	DESCRIPTION / PAYMENT / BALANCE	
OTHER SOURCES (STOCK, BONDS)	$__________	__________ / __________ / __________	
		__________ / __________ / __________	
		__________ / __________ / __________	

*BANK BRANCH (S) & ACCOUNT NUMBERS:

I DECLARE UNDER PENALTY THAT THE ABOVE IS TRUE AND SCRIPPS MAY ACCESS MY CREDIT INFORMATION TO VERIFY THE SAME

______________________________ Signature

__________ (Date)