

How to Apply for Help with Medical Bills at Scripps

Make sure to read everything before you fill out the form.

When you apply for help to pay for your medical care at Scripps, we will check two different programs. One is called Scripps Charity Care program, and the other is called Discount Payment program. To see if you can get help from these programs, your family needs to make a certain amount of money or less.

For Scripps Charity Care program:

- For full help, your family must make 200% or less of Federal Poverty Guidelines.
- If your family makes a little more money, between 201% and 400% of that guideline, you might get some help or discounts.

It is important to give Scripps all the information we ask for so we can figure out the best way to help you. After you give us all the paperwork we need, you will get a letter within 30 days to let you know if you will get help with your medical bills.

STEP 1: Read the list below and pick the best way to show how much money you make. Attach copies of all the papers. Don't send the original papers because you won't get them back. If you forget to send some papers, it might take longer to review your application, or you might not get help from this program.

Income Type	Requested Documentation	
Employment income	Copy of individual tax return (1040 for current tax year) OR Copy of two most recent pay stubs	
Self-employment	Copy of individual tax return (1040 for current tax year including schedule C).	
Social Security/ Retirement	Copy of individual tax return (1040 for current tax year) OR Copy of award letter from Social Security stating monthly payment.	
Disability	Copy of individual tax return (1040 for current tax year) OR Copy of award letter stating disability payment	
Unemployment	Copy of individual tax return (1040 for current tax year) OR Copy of letter stating monthly award amount	

STEP 2. Fill out and sign the attached application.

Need Help with the application? CALL Scripps Financial Assistance Department at (877) 727-4777, Monday through Friday, 8:00 am to 5:00pm

STEP 3. Mail your application with all your paperwork to:

Patient Financial Services Attn: Financial Assistance Dept 10790 Rancho Bernardo Road 4S-303, San Diego, CA 92127

OR you can FAX your application and all your paperwork Fax: (858) 927-5041



Patient Financial Assistance Application

Applicant (Guarantor) Information Name (first name, middle initial, last name) Date of Birth (DOB) (mm/dd/yyyy) Street address City, State, ZIP Medical Record Number Social Security # Home/mobile phone **Guarantor Account Number** Spouse/guardian name (first name, middle initial, last) Date of Birth (DOB) (mm/dd/yyyy) Home/mobile phone Social Security # Will your spouse also be applying for Applicant Identification Number: Medical Record Number financial assistance? ☐ Yes ☐ No FAMILY HOUSEHOLD/DEPENDENTS Household Size: List the number of family members who live with you in your home, such as a spouse, a qualified domestic partner, and dependent children under age 21 or if disabled any age. Include other disabled dependent children of the patient's caretaker. Last Name: Medical Record Number: First Name: DOB: First Name: Medical Record Number Last Name: DOB. Last Name: First Name: DOB: Medical Record Number: First Name: Medical Record Number: Last Name: DOB: Source of Income **Applicant Co-Applicant Combined Monthly Income** Employment/Self Employment Social Security Disability Annuity Alimony

Other

FINANCIAL AGREEMENT AND CREDIT REPORT AUTHORIZATION		
I promise that everything I wrote in this application is true and correct. All the attached documents are real copies of the originals. I understand it is against the law to lie about this information and I won't get help from this program.		
☐ Scripps Health can check my credit report and other sources to see if I qualify		
Signature of Patient/Guarantor	Date (mm/dd/yyyy)	
x		
Signature of Spouse of Patient/Guarantor	Date (mm/dd/yyyy)	
X		

We will send you a letter to let you know if you are able to get help with your medical bills