

Financial Assistance Application

Return to:

Palomar UCSD Health Authority
PO Box 746254
Los Angeles, CA 90074-6254

Fin (Account) #	
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Please provide one or more of the following:

- A. IRS Form W-2, Wage and Earnings Statement for all household earnings
- B. Last two paycheck stubs for all household earnings
- C. Prior year tax returns

And/or provide a copy of one of the following:

- A. Government Assistance, Social Security or Worker's Compensation
- B. Unemployment compensation letter

Patient Information:

Patient Name	
Date of Birth	
Social Security #	
Address	
City, State, Zip	
Phone #	

Family Status:

List all dependents that you support: (if applicable)

Please check box if there are no dependents: ☐

Name	Age	Relationship

Work Status:

Employment and occupation: (if applicable)

Please check box if unemployed: ☐

Employer Name	
Position	
Employer Phone #	
Length of Employment	
Employer Address	
City, State, Zip	

If Self-Employed, Name of Business:

Current Monthly Income:

	Patient/Responsible Party	Spouse
Gross Pay		
Total Combined Monthly Income		
Total Spent on Medical Expenses in the Last 12 Months		

By signing this application, I agree to allow Palomar UCSD Health Authority to contact my employer, bank and other sources, as well as request a credit history for the purpose of determining my Charity Care eligibility. I understand that if I do not qualify for services under the Charity Care guidelines that I will be personally liable for the charges of the services rendered by Palomar UCSD Health Authority. I understand that I am entering into a credit transaction. I authorize Palomar UCSD Health Authority and/or agent of Palomar UCSD Health Authority to access my personal credit profile, credit score or any other information available from a qualified credit reporting agency.

Signature: _____

Printed Name: _____

Relationship to Patient if Signed by Other than Patient: _____

Date: _____