FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Please return completed application and supporting documents to:

L.A. Downtown Medical Center
1711 West Temple Street
Los Angeles, California 90026

Phone Number: **(213) 314-1492**
Email:businessoffice@ladowntownmc.com

Financial Assistance Application
Including List of Required Supporting Documents

This is the application for financial assistance from our Organization. For any questions, please refer to the contact information provided above.

We offer two pathways for financial assistance:

1. **Charity Care**: This is the standard pathway where you can apply for the maximum financial assistance you might be eligible for under our charity care Policy (the "Policy").
2. **Discount Assistance**: This pathway has simplified application requirements for those seeking limited discount assistance.

To be considered for these programs, please complete this application to help us determine your eligibility for a discount. Approval is not guaranteed even if you apply. A written response will be provided regarding the approval or denial once we receive your completed application and documentation.

The Policy covers medically necessary care provided at L.A. Downtown Medical Center and its facilities, (the "Organization").

Submit your completed application by mail or email, and include all requested documents. Missing or unattached documents may result in delays or denial of financial assistance. If you are unable to provide specific documents, please include a letter of explanation.

FAILURE TO PROVIDE ALL REQUIRED INFORMATION MAY RESULT IN DENIAL.

Proof of Income Documents for Application **Documents to Provide:**	**Charity Care**	**Discount Assistance**
Paycheck stubs (prior 2 months)	Required	Required
Federal Tax Return (prior year). See Footnotes 1 and 2 below.	Required	Required
Unemployment, social security or disability verification statements (prior two months)	Required	Optional
Bank statements for all checking, savings, and credit union accounts (prior two months and include all pages).	Required	Optional
Rent or mortgage verification.	Required	Optional
Medi-Cal application response letter (approval or denial), if applicable.	Required	Required

1. If no federal tax return filed, provide most recent W2 or 1099 forms.
2. If federal tax return filing delayed due to temporary disability or unemployment, provide the non-

Spouse/Partner Documents:

- If married, in a civil union, or domestic partnership, provide the applicable "Proof of Income" documents regarding your spouse/partner. See above list of documents, including but not limited to pay checks, verification statements, federal tax returns, W2 or 1099 forms, filing delay forms, bank statements and alimony/child support.

Completed Application:

- Completed application must include date and signature of the applicant.

Election for Discount or Charity Financial Assistance

Applicants for discount or charity financial assistance will only be eligible for financial assistance in an amount up to half of the amount that would be provided for the same service(s) under an application for full financial assistance.

FINANCIAL ASSISTANCE APPLICATION

Please check the type of financial assistance you are interested in applying for:

☐ Limited Financial Assistance (capped, ranging from 0% to 50%)
☐ Complete Financial Assistance (no cap, ranging from 0% to 100%)

PATIENT INFORMATION

<table>
<tr><td colspan="2">Patient Name</td><td colspan="2">Social Security Number</td><td colspan="2">Date of Birth</td></tr>
<tr><td colspan="2">Home Address</td><td colspan="2">City</td><td>State</td><td>Zip Code</td></tr>
<tr><td>Home Number</td><td>Cell Number</td><td colspan="4">Email Address</td></tr>
<tr><td colspan="3">Preferred Method of Contact

☐ US Mail ☐Email ☐Home Phone ☐ Cell Phone</td><td colspan="3">Annual Household Income:

$____________________</td></tr>
<tr><td colspan="3">Marital Status: ☐Married ☐Single ☐Separated
☐ Divorced ☐Widowed
☐Domestic Partner</td><td colspan="3">Number of Individuals in your Household (as reported on your taxes):</td></tr>
<tr><td colspan="6">Employment Status
☐ Employed ☐Self-employed ☐Retired ☐Disabled
☐ Unemployed - Last date worked: _______________</td></tr>
<tr><td colspan="3">Employer Name</td><td colspan="3">Phone Number</td></tr>
<tr><td colspan="3">Employer Address</td><td>City</td><td>State</td><td>Zip Code</td></tr>
</table>

SPOUSE/ DOMESTIC PARTNER/ PARENT/ GUARANTOR INFORMATION

<table>
<tr><td colspan="3">Relationship to Patient
☐ Spouse ☐Domestic Partner ☐Parent ☐Guarantor ☐Other: __________________</td></tr>
<tr><td>Name</td><td>Social Security Number</td><td>Date of Birth</td></tr>
</table>

Employment Status			
☐ Employed ☐Self-employed ☐Retired ☐Disabled ☐Unemployed - Last date worked: ______			
Employer Name	Phone Number		
Employer Address	City	State	Zip Code

INSURANCE COVERAGE

Are you eligible for any health insurance coverage? ☐ **Yes** ☐ **No** If yes, please provide following:

Policy Holder	Insurer	Policy Number
Policy Holder	Insurer	Policy Number

EXPENSE AND ASSET INFORMATION

Current Monthly Income	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Gross Pay	$	$	$
Net Self-Employed Income	$	$	$
Interest and Dividends	$	$	$
Real Estate or Rental Property	$	$	$
Social Security/Retirement/Disability	$	$	$
Alimony, Support Payments	$	$	$
Other	$	$	$
Total Monthly Income	$	$	$

Essential Living Expenses	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Rent or Mortgage	$	$	$
Real Estate Taxes	$	$	$
Utilities and Telephone	$	$	$
Alimony, Support Payment	$	$	$
Auto Loan/Lease Payment	$	$	$
Education	$	$	$
School/Childcare (Minor Dependents)	$	$	$
Food	$	$	$
Insurance	$	$	$
Other Expenses	$	$	$
Total Monthly Expenses	$	$	$

Current Medical Debt	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Outstanding Medical Debt (Cedars-Sinai)	$	$	$
Other Medical Debt	$	$	$

Assets (Exclude Retirement)	**Patient/Guarantor**	**Spouse/Partner**	**Total**
Checking/Savings/Credit Union	$	$	$
Stocks and Bonds	$	$	$
Money Market/Brokerage	$	$	$
Certificates of Deposit	$	$	$
Total Assets	$	$	$

I certify that the information in this application is true and correct to the best of my knowledge. I agree to apply for any local, state, and federal assistance for which I may be eligible, to help alleviate the cost of any hospital and professional bills. I understand that the information provided may be verified by the Organization and I authorize them to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provided incorrect information or if the application contains a material error or omission, I will no longer be eligible for financial assistance. If financial assistance was previously granted to me, it may be reversed at that time, and I will be held responsible for the outstanding balance.

Signature of Person Applying for Financial Assistance — Date

Spouse/Domestic Partner/Guarantor Signature (if applicable) — Date