CEDARS-SINAI

**APPLICATION FOR FINANCIAL ASSISTANCE**

Patient Name:

Patient Account or Medical Record Number:

Date of Birth: Last 4 Digits of Social Security #: xxx-xx-

Best Daytime Telephone Number:

Address:

City: State: Zip:

Spouses Name: Last 4 Digits of Social Security # : xxx-xx-

Are you a U.S. Citizen? ◯ ◯

If not, a resident alien? ◯ ◯

If not, a non-resident alien? ◯ ◯

**Family Status: List all dependents that you support (if more than 4 use separate page)**

Name Age Relationship

**Employment and Occupation**

Employer: Position:

If self-employed, name of business:

Employer address:

Phone: How long employed:

Spouses Employer: Position:

If self-employed, name of business:

| Currently Monthly Income | Patient | Spouse | 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 | Spouse | 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 | Spouse | Total |
|---|---|---|---|
| Outstanding Medical Debt (Cedars-Sinai) | $ | $ | $ |
| Other Medical Debt | $ | $ | $ |
| Utilities and Telephone | $ | $ | $ |

| Assets (Exclude Retirement Accounts) | Patient | Spouse | Total |
|---|---|---|---|
| Stocks and Bonds | $ | $ | $ |
| Money Market/Brokerage Accounts | $ | $ | $ |
| Certificates of Deposit | $ | $ | $ |
| Total Assets | $ | $ | $ |

By signing this application, I agree to allow Cedars-Sinai to check my employment and request a credit history.

_____ _____

(Signature of Patient) (Date)

_____ _____

(Signature of Spouse) (Date)