Keck Hospital of USC, USC Norris Cancer Hospital, USC Verdugo Hills Hospital (VHH), and USC Arcadia Hospital (UAH) are dedicated to providing quality health care to our patients. We realize that payment for services may be a financial hardship for you at this time. Keck Medicine of USC, USC Verdugo Hills Hospital and USC Arcadia offers Financial Assistance to aid those that may qualify to reduce or eliminate their cost of care obligation.

Attached with this letter, you will find an application to enable an evaluation of your financial hardship. You must complete the application in order to be considered for the financial assistance program. If your financial situation meets the eligibility criteria set forth by the Keck Medicine of USC, USC Verdugo Hills Hospital and USC Arcadia Financial Assistance Program, you may be eligible for full or partial forgiveness of debt.

In order to process this application, we require:

- The enclosed application completed in its entirety.
- You must sign and date the financial assistance application. If the patient/guarantor and/or spouse provide information, both must sign the application.
- Copy of your most recent cancelled rent check, lease agreement or mortgage payment.
- Copy of the last two pay stubs for any wage earned contributing to the household income.
- Copy of your two most current bank statements (checking/savings).
- Copy of your disability, social security payment statement, unemployment notice of eligible benefits and bank statement reflecting deposits.
- If you do not have a source of income or proof of income documents, please provide a letter explaining how you support yourself and your family. This is a written and signed statement from a family member or friend who is providing your room and board and/or income.
- Copy of your most recent tax return, including all applicable schedules and attachments submitted to the Internal Revenue Service.
- If your most recent tax return is not available, then we will need one of the following:
    - Social Security Awards Letter
    - Proof of non-filing from the IRS (call 800-829-1040 to obtain a copy)
      If you have not filed a current federal tax return and have requested an extension for taxes, please include, along with the previous year's tax returns

We realized that your income from previous tax records may not adequately reflect your current circumstances. It is important that you complete and submit the completed Financial Assistance Application along with all the required documents within fifteen (15) days.

Keck Medicine of USC

Keck Hospital of USC | USC Arcadia Hospital | USC Norris Cancer Hospital | USC Verdugo Hills Hospital

Please send your Financial Assistance Application and required documents:

****For USC Arcadia Hospital:**

- Mail: USC Arcadia Hospital
  Attention: Business Office- Patient Financial Services
  300 Huntington Drive
  Arcadia CA 91007

*****For Keck Medicine of USC, USC Norris Cancer Hospital, and USC Verdugo Hills Hospital:**

- Mail: Keck Medicine of USC
  Attention: Financial Assistance Coordinator
  1000 S Fremont Ave
  Unit 16, Building A13
  Alhambra CA 91803
- Secure Fax:
  - For all Facilities: 323-865-5672
- Email: pfscustomerservice@med.usc.edu

Contact information:
USC Arcadia Hospital:

- Contact the Financial Assistance Coordinator
  - Call: 626-574-3594

Keck Hospital – USC Norris Cancer Hospital- USC Verdugo Hills Hospital:

- Contact the Financial Assistance Coordinator
  - Call: 855-532-5729

Once we have reviewed your application, we will notify you of our decision in writing as soon as possible. If you wish to discuss your account or have any questions, please contact Patient Financial Services at 855-532-5729 for Keck Hospital, USC Norris Caner Hospital or USC Verdugo Hills Hospital.

For USC Arcadia Hospital please call 626-574-3594

Our business hours are Monday – Friday, 8:00 am to 5:00 pm PST.

Keck Medicine of USC

Keck Hospital of USC | USC Arcadia Hospital | USC Norris Cancer Hospital | USC Verdugo Hills Hospital

FINANCIAL ASSISTANCE APPLICATION

Demographic Information

Name	Date of Birth	Spouse/Partner	Date of Birth	
Address		City	State	Zip
Time at Present Address _____Rent ____Own ____Years ____Months		County	Marital Status __Married __Single __Divorced __Widowed	
Cell Number	Work Number	Home Number	Spouse Cell Number	Spouse Work Number

Please list ALL persons living in your household; including dependents (Attached an additional sheet if needed)

Last Name	First Name	MI	Date of Birth	Relationship to Applicant
1				
2				
3				
4				

Self		Spouse	
Social Security#		Social Security#	
Employed By		Employed By	
Business Address		Business Address	
Occupation		Occupation	
Length Employed __Years __Months __Hours worked per week		Length Employed __Years __Months __Hours worked per week	

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Source of Income

Income: Represents total cash receipts from all sources before taxes.

	Self Monthly Gross		**Spouse Monthly Gross**
Gross Income		Gross Income	
Social Security/SSI/SSDI		Social Security/SSI/SSDI	
Public Assistance		Public Assistance	
Rental Property Income		Rental Property Income	
Work Comp		Work Comp	
Unemployment		Unemployment	
Child Support		Child Support	
Other		Other	
TOTAL		**TOTAL**	

Assets/Property

Checking		Cash on Hand			
Savings		Trust Account			
Stock/Bonds		Credit Union		Other	

Monthly Expense

House Payment/Rent	Auto Insurance	Life Insurance	Health Insurance
Property Tax	Phone/Cell Phone	Food	Water and Sewer
Property Insurance	Vehicle Payment	Daycare Expense	Medical Expenses
Gas	Vehicle Payment	Child Support Expense	Other/Specify:
Electric			**TOTAL**

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Required Documents:

- Proof of Income (i.e. 2 Pay stubs for each wage earner, SS, SSI, SSDI, Public Assistance, Rental Income, Retirement, Pension, VA Benefits, Unemployment, Workers Comp, Child Support, Alimony, or Other)
- Copy of your most recent tax return, including all applicable schedules and attachments
- Copy of your two most current bank statements (checking/savings)
- Copy of your most recent cancelled rent check, lease agreement or mortgage payment
- Written statement from a family member or friend who is providing your room and board and/or income.
- Complete Financial Assistance Application

ASSIGNMENT OF RIGHTS

By signing below, I declare under penalty of perjury that the information and statements contained in this Application for Financial Assistance and all documentation which I submit are accurate true and correct. You are hereby authorized to check my credit history in order to evaluate this application for Financial Assistance consideration.

- I understand that Keck Medicine of USC, USC Norris Caner Hospital, USC Verdugo Hills Hospital, and USC Arcadia Hospital may make reasonable requests for additional information and verification if necessary.
- I understand that the information and statements I have provided will be kept confidential by Keck Medicine of USC, USC Norris Caner Hospital, USC Verdugo Hills Hospital, and USC Arcadia Hospital.
- I understand that the completion of the application will allow Keck Medicine of USC, USC Norris Caner Hospital, USC Verdugo Hills Hospital, and USC Arcadia Hospital to consider my circumstances.
- I understand Keck Medicine of USC, USC Norris Caner Hospital, USC Verdugo Hills Hospital, and USC Arcadia Hospital makes no representation that financial assistance is guaranteed.

I/We hereby certify the above information and voluntarily authorize you to obtain credit information relative to me/us.

Signature Date Signature Date

Keck Medicine of USC

Keck Hospital of USC | USC Arcadia Hospital | USC Norris Cancer Hospital | USC Verdugo Hills Hospital

Additional Information (if needed) :

This space can be used to clarify and explain why you are unable to provide the required documents listed above.


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USC Arcadia Hospital
USC Norris Cancer Hospital
USC Verdugo Hills Hospital