FINANCIAL ASSISTANCE

Torrance Memorial Medical Center ("TMMC") provides a Financial Assistance Program to our patients who are unable to afford the cost of their medical care. TMMC has two pathways for financial assistance. One is the usual pathway of applying for the maximum financial assistance ("Comprehensive Financial Assistance") that you might be eligible for under our Financial Assistance Policy (the "Policy"). The Policy applies to services provided by TMMC, as well as physicians who are required to participate in the Policy as a condition of their contractual relationship with TMMC (see Attachment D of the Policy for a complete list of those who participate in the Policy). Elective/Cosmetic services and any other providers of service outside of the areas mentioned above may not be covered under this program. The second pathway has abbreviated application requirements for patients seeking limited financial assistance ("Limited Financial Assistance").

To be considered for these financial assistance programs, please complete this application to help TMMC determine whether you may qualify to receive a discount. We cannot guarantee that you will qualify, even if you apply. A written response will be provided to all patients supporting approval/denial after we receive your completed application and documentation.

You may submit the completed application by mail or in person to the address listed below. Provide all documents requested below. Missing or unattached documents may cause a delay or denial of financial assistance. If unable to provide specific documents, please provide a letter of explanation.

FAILURE TO PROVIDE ALL REQUIRED INFORMATION MAY RESULT IN DENIAL.

PLEASE NOTE: IF YOU ARE UNINSURED AND MEET SPECIFIC MEDI-CAL PRESUMPTIVE ELIGIBILITY CRITERIA, YOU ARE NOT REQUIRED TO COMPLETE THIS APPLICATION.

Proof of Income Documents for Application Documents to Provide:	**Comprehensive Financial Assistance**	**Limited Financial Assistance**
Paycheck stubs (prior 2 months)	Required	Required
Federal Tax Return (prior year). See Footnotes 1 & 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	Optional

[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-filing tax form. Obtain copies by calling 1-800-908-9946 or visiting www.irs.gov/individuals/get-transcript (use form 4506-T or 4506T-EZ).

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, and Spouse/Domestic Partner/Guarantor (if applicable).

Please return completed application and supporting documents to:

Torrance Memorial Medical Center
Attn: Business Office
3330 Lomita Boulevard
Torrance, CA 90505

More Help

For assistance or additional information about our Financial Assistance Program, including obtaining translated or accessible financial assistance-related documents, you can contact the Business Office between 8:00 am to 4:00 pm Monday through Friday:

- In Person – at the address above
- By Telephone – at 310-517-1010

TMMC's website also provides information about our Financial Assistance Program at https://www.torrancememorial.org/patients-visitors/billing-insurance/help-paying-your-bill.

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				
Patient Name		Social Security Number	Date of Birth	
Home Address		City	State	Zip Code
Home Number	Cell Number	Email Address		
Preferred Method of Contact ☐ US Mail ☐Home Phone ☐ Cell Phone		Annual Household Income: $ _____		
Marital Status: ☐Married ☐Single ☐Separated ☐ Divorced ☐Widowed ☐Domestic Partner		Number of Individuals in your Household (as reported on your taxes):		
Employment Status ☐ Employed ☐Self-employed ☐Retired ☐Disabled ☐ ☐Unemployed - Last date worked: _____				
Employer Name		Phone Number		
Employer Address		City	State	Zip Code

SPOUSE/ DOMESTIC PARTNER/ PARENT/ GUARANTOR INFORMATION

Relationship to Patient
☐ Spouse ☐Domestic Partner ☐Parent ☐Guarantor ☐Other: _____

Name	Social Security Number	Date of Birth

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**
Medical Debt	$	$	$

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