CAMPUS MEDICAL CARE ASSISTANCE FUND (CMCAF)

2024-2025 Appication

The Campus Medical Care Assistance Fund (CMCAF) was established to provide financial assistance, in the form of a grant, to UC SHIP students and enrolled dependents who are experiencing significant out of pocket medical expenses due to an unforeseen medical emergency. Grants may be requested for $500 up to the student's campus in-network individual out-of-pocket maximum. If awarded, student must consult a tax professional to determine if grant award is taxable.

CMCAF APPLICANT ELIGIBILITY REQUIREMENTS:

- The student or dependent must be currently enrolled in UC SHIP and enrolled for at least one term before the date of the medical service; the medical service date must be during the 2024-2025 plan year.
- The student must be in good financial standing (no UC student account balance) at the University of California campus, even if the funds are for a dependent's medical expenses.
- Only medically necessary services listed on the CMCAF FAQ are eligible for grant consideration.
- The student must have exhausted all other means of payment with proof of applying for Charity Care with the medical provider of service.

CMCAF PROCESS:

The UC SHIP enrolled student must complete, sign and submit this application along with the below documentation in a secure manner to the campus student health center insurance office:

- Copy of Explanation of Benefits (EOB) from Anthem;
- Copy of the bill from the provider of service indicating the student's/dependent's outstanding balance;
- The written response to your request for Charity Care from the medical provider of service.

CMCAF APPLICATION:

APPLICATION DATE: STUDENT IS A: Graduate ☐ or Undergraduate ☐

STUDENT'S NAME:

CAMPUS NAME: STUDENT'S CAMPUS ID #:

PATIENT INFORMATION: Patient is the UC SHIP enrolled: Student ☐ Dependent ☐

PATIENT'S NAME:

PATIENT'S ANTHEM MEDICAL ID #:

ADDRESS:

CITY: STATE: ZIP CODE:

EMAIL ADDRESS: PHONE NUMBER:

CAMPUS MEDICAL CARE ASSISTANCE FUND (CMCAF) **APPLCATION**

MEDICAL SERVICE PROVIDER'S INFORMATION:

MEDICAL PROVIDER'S NAME:

ADDRESS:

CITY: STATE: ZIP CODE:

EMAIL ADDRESS: PHONE NUMBER:

GRANT REQUEST INFORMATION:

DATE OF MEDICAL SERVICE: AMOUNT REQUESTING:

REASON FOR REQUESTING FUNDS:

BY WHAT MEANS HAVE YOU TRIED TO RESOLVE THIS FINANCIAL OBLIGATION:

STUDENT SIGNATURE: _____ **DATE**: _____

FOR STUDENT HEALTH CENTER INSURANCE STAFF

RECEIVED BY: _____ DATE RECEIVED: _____

ALL DOCUMENTATION INCLUDED: YES NO – Missing documentation, if any: _____

_____

_____

FOLLOW UP NOTES, if needed: _____

_____

_____

_____

GRANT AMOUNT AWARDED: _____ DATE AWARDED: _____

LEDGER TRANSACTION NUMBER: _____