CAMPUS MEDICAL CARE ASSISTANCE FUND (CMCAF)

2023-2024 Application

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 $2500 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 2023-2024 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’S NAME: ____________________________________________________________
CAMPUS NAME: ___________________ STUDENT’S CAMPUS ID #: __________________

PATIENT INFORMATION: Patient is the UC SHIP enrolled _____ OR Student Dependent _____

PATIENT’S NAME: ______________________________________________________

PATIENT’S ANTHEM MEDICAL ID #: ________________________________________

ADDRESS: ____________________________________________________________________________

CITY: _____________________________ ZIP CODE: _______________

EMAIL ADDRESS: __________________________________________

STATE: ____________________________

PHONE NUMBER: ____________________________

STUDENT IS A: Graduate _____ or Undergraduate ______

MEDICAL SERVICE PROVIDER’S INFORMATION

MEDICAL PROVIDER’S NAME: ____________________________________________

ADDRESS: ____________________________________________________________________________

CITY: _____________________________ ZIP CODE: _______________

EMAIL ADDRESS: __________________________________________

STATE: ____________________________

PHONE NUMBER: ____________________________

GRANT REQUEST INFORMATION: $______________

DATE OF MEDICAL SERVICE: ___________________________ AMOUNT REQUESTING: ____________

REASON FOR REQUESTING FUNDS: ______________________________________________________

STUDENT SIGNATURE: _______________________________  DATE: _________________

FOR STUDENT HEALTH CENTER INSURANCE STAFF

RECEIVED BY: _____________________________ DATE RECEIVED: ____________________________

ALL DOCUMENTATION INCLUDED: YES_____ OR NO_____ – Missing documentation, if any: ____________________________________________________________________________

FOLLOW UP NOTES, if needed: __________________________________________

GRANT AMOUNT AWARDED: ____________________ DATE AWARDED: ____________________________