CAMPUS MEDICAL CARE ASSISTANCE FUND (CMCAF)

2024-2025 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 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'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:_____