CAMPUS MEDICAL CARE ASSISTANCE FUND (CMCAF)



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 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 IS A: 0	Graduate or Undergraduate	
STUDENT'S NAME:			
CAMPUS NAME:	STUDENT'S CAMPUS ID #:		
PATIENT INFORMATION: Patient is the PATIENT'S NAME:	UC SHIP enrolled: Stude	ent Dependent	
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 I	RESOLVE THIS FI	NANCIAL OBLIGATION:
STUDENT SIGNATURE:		DATE:
FOR STUDENT HEALTH	I CENTER INSU	RANCE STAFF
RECEIVED BY:	DATE RECEIVED:	
ALL DOCUMENTATION INCLUDED: YES		
FOLLOW UP NOTES, if needed:		
GRANT AMOUNT AWARDED:		DATE AWARDED:
LEDGED TO ANGLOTION AND DED		

UC SHIP - June 2023 Page 2 of 2