Dear UCSF Health Patient or Patient Representative:

Please find the enclosed Financial Assistance Application.

UCSF Health is committed to advancing healthcare for all members of the community. We treat all patients who require our services, without regard to race, color, religion, national origin, citizenship or other protected characteristics. Our financial assistance policy and determination process adheres to this value**. While California residency is a requirement for financial assistance, Patient Financial Services will not solicit proof of citizenship or Legal Residency as demonstration of California residency.** For more information about UCSF Health's Mission and Values, please visit: https://www.ucsfhealth.org/about/our-mission/

Income verification must be included for the application to be processed. Please provide all information to avoid delays in processing. Application will be returned if supporting documentation is missing. Acceptable proof of income includes:

- Copy of most recent (2 months) pay stubs for both applicant & co-applicant.
- Copy of current year W-2 or 1099 earnings statements for both applicant & co-applicant.
- Copy of signed current year's Income Tax Return (for both applicant & co-applicant)
- Copy of current Social Security Allotment letter and/or other proof of income

** Bank statements will not be accepted as proof of income.

You may return the completed Financial Assistance Application to:

UCSF Health Patient Financial Services
Attn: Financial Assistance & Charity Care Unit
Box 0810
San Francisco, CA 94143-0810

You can also make your credit card payment online at https://www.ucsfhealth.org/mychart/

If you have any further questions and/or concerns, please contact Patient Financial Services at (866) 433-4035.

Note:
Services deemed as not medically necessary or experimental are not eligible for financial assistance. Self-pay patients (no insurance coverage) must provide a Notice of Action Letter from Medi-Cal Indicating that he/she applied but was deemed ineligible.

Financial Assistance Application

1. PATIENT INFORMATION				
Last Name	**First Name**	**Initial**	**Guarantor Account No.**	**Med. Record No.**

2. APPLICANT INFORMATION	**RELATIONSHIP TO PATIENT** ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** _____	**Marital Status** ☐ Married ☐ Single ☐ Separated **IF MARRIED, SECTION 3 MUST BE COMPLETED**	
Last Name	**First Name**		
Date of Birth	**No. of Dependents** (under age 21, other than self & spouse)	**Ages of Dependents**	**Home Phone** ( )

Street Address (Do Not List PO Box)	**City**	**State**	**County**	**Zip**

Current Employer	**Street Address, City, State**	**Position**

3. CO-APPLICANT INFORMATION			**RELATIONSHIP TO PATIENT** ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** _____
Last Name	**First Name**	**Initial**	**Relationship to Applicant**

Date of Birth	**No. of Dependents** (do not include those claimed by applicant)	**Ages of Dependents**	**Home Phone** ( )

Street Address (Do Not List PO Box)	**City**	**State**	**County**	**Zip**

Current Employer	**Street Address, City, State**	**Position**

UCSF Health

4. INCOME INFORMATION **(Supporting documentation required. To list additional income, use back of this application)**				**Combined Monthly Income**
	Monthly Income Sources	**Applicant**	**Co-Applicant**	
	Employment Income	$	$	$
	Social Security	$	$	$
	Alimony/Child Support	$	$	$
	Other: (*Unemployment, Disability, Pension, etc*.)	$	$	$
		Total Combined Monthly Income		$

5. ASSETS **(To list additional assets, use back of this application)**			
Checking/Money Market/Savings Accounts:			
Bank Name:	**Branch/Address**		**Monthly Balance/ Value**
1.			$
2.			$
Other Cash Assets:			$
		Total Asset Value	$

6. SUPPORTING DOCUMENTATION (REQUIRED)

Application will be returned if supporting documentation is missing. Acceptable proof of income includes:
(Bank statements will not be accepted as proof of income)

From both applicant & co-applicant

- ✓ Copy of most recent (2 months) pay stubs for **both** applicant & co-applicant.
- ✓ Copy of current year or previous year's W-2 or 1099 earnings statements for **both** applicant & co-applicant.
- ✓ Copy of **signed** current year's or previous year's Income Tax Return
- ✓ Copy of Social Security Allotment letter and/or other proof of income **(section 4)**

7. COMMENTS

Enter any additional information relevant to your request not reflected on this application.

UCSF Health

8. SIGNATURE AND DATE (REQUIRED OF APPLICANT AND CO-APPLICANT)

I certify that all information is true and complete, and hereby authorize UCSF Medical Center to request a credit check report and/or verify any of the above information as deemed necessary. I understand that incomplete applications will be returned to the applicant. I understand that I may be required to complete a new application for future services. I agree to notify UCSF Medical Center of any changes to my financial circumstances that may affect my eligibility for financial assistance.

Applicant	**Date**	**Co-Applicant**	**Date**
_____		_____	