



Please find the enclosed Financial Assistance Application. 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

Note: 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
- Copy of valid Legal Permanent Resident card if non-US citizen is required.

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

Financial Assistance is available only to residents of California.

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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <u>IF MARRIED, SECTION 3 MUST BE COMPLETED</u>		
Last Name	First Name	U.S. Citizen (see #6) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of Birth	No. of Dependents <small>(under age 21, other than self & spouse)</small>	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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____		
Last Name	First Name	Initial	Relationship to Applicant	U.S. Citizen (see #6) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth	No. of Dependents <small>(do not include those claimed by applicant)</small>	Ages of Dependents		Home Phone ()	
Street Address (Do Not List PO Box)	City	State	County	Zip	
Current Employer	Street Address, City, State		Position		

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: (<i>Unemployment, Disability, Pension, etc.</i>)	\$	\$		\$
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**)
- ✓ Copy of valid Legal Permanent Resident card if non-US citizen is required.

7. COMMENTS

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



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
