



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 United States residency is a requirement for financial assistance, Patient Financial Services will not solicit proof of citizenship or Legal Residency as demonstration of residency.** For more information about UCSF Health's Mission and Values, please visit: <https://www.ucsfhealth.org/about/our-mission/>. For Help Paying Your Billing, please visit: <https://www.ucsfhealth.org/billing-and-insurance/help-paying-your-bill> .

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
- Please note: Bank statements will not be accepted as proof of income.

For fastest assistance, please apply for Financial Assistance on MyChart. Please visit: <https://www.ucsfhealth.org/mychart>.

For paper applications, please scan and return the completed Financial Assistance Application, together with the supporting documents, by email to [FinancialAssistance@ucsf.edu](mailto:FinancialAssistance@ucsf.edu).

If you are submitting paper documents by mail, please remember to include the supporting documents listed above and mail the application and supporting documents to:

**UCSF Health Patient Financial Services**  
**Attn: Financial Assistance & Charity Care Unit**  
**6425 Christie Avenue Suite 500**  
**Emeryville, CA 94608**

If you have any further questions and/or concerns, please contact Patient Financial Services at (866) 433-4035. (8 am to 4 pm Pacific Time, Monday – Friday, excluding holidays).

**Any services considered not medically necessary are not eligible for financial assistance.**



## Financial Assistance Application

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

2. APPLICANT INFORMATION		RELATIONSHIP TO PATIENT	Marital Status		
		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent Other _____	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <b>IF MARRIED, SECTION 3 MUST BE COMPLETED</b>		
Last Name	First Name	U.S. Citizen			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of Birth	No. of Dependents <small>(under age 21, other than self &amp; 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"/> Spouse <input type="checkbox"/> Parent   Other _____		
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> )	\$	\$	\$
<b>Total Combined Monthly Income</b>				\$

**5. Medical Expenses Last 12 months:**

**UCSF Accounts**

Account ID	Guarantor	Amount Paid	Remaining Balance
1.			\$
2.			\$
3.			\$

Medical Expense Outside UCSF

Medical or Hospital Provider	Dates of Service	Amount Paid	Remaining Balance
1.		\$	\$
2.		\$	\$
3.		\$	\$

If you need to detail additional information, please attach a sheet to this application listing additional medical expense.

**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.

**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**