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 assitance, please apply for Financial Assitance 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**.**

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.

UCSF Health

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**	**U.S. Citizen** ☐ Yes ☐ No

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** ☐ **Spouse** ☐ **Parent** **Other** _____

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**

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. 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)**

UCSF Health

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**
_____		_____	

Rev: 7/9/2024