



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, including unemployment benefits.
- ** Bank statements will not be accepted as proof of income

Updated Income Verification Requirements Related to COVID-19:

We understand that many in our community may be impacted by the financial hardship caused by COVID-19. We are here to help.

- If your current year (2019)'s Income Tax Return has not been filed yet, please provide the previous year (2018)'s Tax Return.
- If you have filed for unemployment benefits, please provide your monthly (or bi-weekly) statement showing the current benefit amount that you are receiving.
- If you have other financial hardships due to COVID-19, please provide an explanation using the "Comments" section of the 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

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 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> 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	



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**)

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
