



SMMC Financial Assistance Program Application

Applicant Information

Name:		MRN:
Date of birth:	SSN:	Phone:
Current address:		Other Phone:
City:	State:	ZIP Code:

Household Information

Family size:	Family Gross Monthly Income	\$
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Visit Information

Date(s) of medical bill(s) that need to be covered:

Is this visit due to a work-related injury or automobile accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have public or private medical insurance or coverage through a Federal, State, or County program (e.g., HMO/PPO, Medicare, Medi-Cal, Covered CA, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, why do you need financial assistance with this visit?

Coinsurance Date of service outside of coverage period
 Deductible Other _____
 Out of network cost

Charity Care Acknowledgements

- To qualify for Charity Care, my household income must be 138% or below the Federal Poverty Level.
- Charity Care is not an insurance program and is only valid at San Mateo Medical Center facilities.
- The scope of services eligible for Charity Care includes all SMMC services except for prescription benefits.
- My application for Charity Care is requesting coverage for only the specific visits I'm applying for.
- If approved for Charity Care, the charges for the visits approved will be waived.

My initials indicate that I have read, understood, and acknowledge each statement above: _____

DHC Acknowledgements

- To qualify for DHC, my household income must be 400% or below the Federal Poverty Level.
- DHC is not an insurance program and is only valid at pre-approved San Mateo Medical Center facilities and associated pharmacies.
- When I select a Primary Care Provider Clinic, I am also selecting a pharmacy where I will get my prescriptions.
- My eligibility for DHC will expire one year from the program's effective date and I must thereafter reapply. The eligibility period may include retroactive coverage.
- I will be required to provide a deposit of \$150 at every clinic and Emergency room visit. This amount will be applied to the visit and the difference will be billed.
- For inpatient services, I am expected to pay a 50% deposit of the expected *discounted* charges, up to a maximum of \$5000.00.
- If approved for DHC, I will receive a 65% discount of charges which means I will pay no more than the highest amount that the San Mateo Medical Center would receive for providing the medical services in question from Medicare, Medi-Cal, or any other government-sponsored health benefit program in which San Mateo Medical Center participates.
- I understand that an interest-free extended repayment plan is available to me, the terms of which will be based on my ability to pay.

My initials indicate that I have read, understood, and acknowledge each statement above: _____

If you'd like to apply for a health coverage program or have questions about your eligibility, please contact the Health Coverage Unit at 650-616-2002 or Info-HCU@smcgov.org.





Charity Care and DHC Acknowledgements

1. Only uninsured and underinsured patients qualify for Charity Care or DHC. An underinsured patient is one who has a third-party insurance with a high-cost deductible, co-insurance, or out of pocket medical expense.
2. I acknowledge that I have received information about the Financial Assistance Programs.
3. I understand that if I am asked to apply for Medi-Cal or any other program, I must do so.
4. The Charity Care/DHC application must be submitted within 180 days from initial issuance of a bill. Any applications received after 180 days will be considered on a case-by-case basis.
5. I understand that if the information I provide as part of my application is found to be inaccurate, I will be immediately disqualified from Charity Care or DHC and may be billed retroactively for all services previously covered under these programs. I understand that providing false information to wrongfully obtain benefits may be a reportable offense.
6. Charity Care and DHC waivers and discounts will only apply to charges billed by SMMC. SMMC contracted emergency room providers bill separately; patients may seek financial assistance directly from the contracted providers.
7. I understand that I must submit proof of my household income including: a recent employment paystub, government check stub or letter (unemployment or disability), or federal tax forms from the previous year.
8. I understand that I should send photocopies only and NOT originals, as original documentation will not be returned.
9. The applicant has 45 days from the application date to provide required documentation. If it is not provided within 45 days, the application will be denied. The applicant will receive a written notice that the application has been denied based on his/her failure to provide necessary verifications.
10. Individuals who apply for Charity Care or DHC will be informed in writing if they qualify. The letter will be provided to the applicant within 45 days after receipt by the County of a complete application and it shall provide information about the right to appeal a denial.
11. I understand that if I am denied eligibility, disenrolled from Charity Care or DHC for any reason, or wish to request a waiver or reduction of charges, I have the right to a two-step appeals process that allows me to present evidence of eligibility or argue special circumstances based on my inability to pay.
 - a. The first appeal step is an Individual Eligibility Review (IER) to appeal any financial and non-financial issues relating to my eligibility and ability to pay.
 - i. I may mail an appeal request within 60 days after notice of denial or disenrollment to Sarita Llamas, Appeals Coordinator, 801 Gateway Blvd., Ste 300, South San Francisco, CA 94080 or I may e-mail it to: sllamas@smcgov.org.
 - ii. It must include a statement setting forth the basis of the appeal and any verifications that may support eligibility.
 - iii. I will receive a written response within 30 days from the date my appeal request was received.
 - b. If I am not satisfied with the decision from the IER process, I can submit the Step 2 appeal to the Appeals Coordinator, and it will be decided upon by the Eligibility and Financial Review Committee (EFRC).
 - c. If I have any questions about the appeal process, I can call the Appeals Coordinator at **650-670-5727**.
11. The Legal Aid Society of San Mateo County's **Health Consumer Center** helps county residents navigate the healthcare system and offers information, advice, and representation. For more information call (650) 558-0915 or visit <https://www.legalaidsmc.org/>.

I declare that the above information is true and correct. Further, by signing below, I hereby authorize County personnel, agents or contractors, to verify and/or investigate my eligibility. Such investigation/verification may include the obtaining and use of information and documents possessed by other public and private agencies.

My signature indicates I have read and acknowledge each statement above and agree to be enrolled in Charity Care or DHC.

Signature of applicant:	Date:
FOR DEPARTMENT USE ONLY	
Date of Eligibility Determination:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
Staff Signature:	Date:

