Stanford MEDICINE
Health Care

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

This is an application for financial assistance (also known as charity care) at Stanford Medicine. For purposes of financial assistance, "Stanford Medicine" includes Stanford Medicine Health Care, Stanford Medicine Tri-Valley, and Stanford Medicine Partners. Stanford Medicine offers financial assistance to uninsured patients who have family income that is 400% or less than the Federal Poverty Level, and to insured patients who have family income that is 400% or less than the Federal Poverty Level and have high out-of-pocket amounts (10% or more of family income). Financial assistance is only available for services provided by Stanford Medicine.

Stanford Medicine has a variety of financial assistance programs available to patients. Our financial assistance options include:

No Financial Assistance Application Required

- **Uninsured Discounts —** All uninsured patients will automatically receive a discount off of Stanford Medicine's charges. Some services are not eligible for the uninsured patient discounts – contact Customer Service Billing for more information.

Financial Assistance Application Required

- **Full Financial Assistance —** Uninsured patients who have family income that is 400% or less than the Federal Poverty Level, and insured patients who have family income that is 400% or less than the Federal Poverty Level and have high out-of-pocket amounts (10% or more of family income), are eligible for a discount of 100% of the amount due from the patient. Some services are not eligible for financial assistance – contact Customer Service Billing for more information**.**

Extended No Interest Payment Plans

- Patients may request an extended payment plan for their balances due. All payment plans are interest-free. Patients have the right to negotiate the terms of their payment plan.

In order for your financial assistance application to be processed, you must:

- Provide us information about your family; fill in the number of family members, which can include:
  When patient is 18 years of age or older, family includes:
  - Patient
  - Spouse
  - Registered domestic partner
  - Dependent children under 21
  - Dependent children of any age if disabled

  When patient is under 18 years of age, or 18-20 years of age if a dependent, family includes:
  - Patient
  - Patient's parent(s)
  - Patient's caretaker relative(s)
  - Other dependent children of the parent(s) or caretaker relative under 21 years of age
  - Other child(ren) of the parent(s) or caretaker relative of any age if the child(ren) is disabled
- Provide us information about your family's gross monthly income (income before taxes and deductions)
- Attach additional information if needed
- Sign and date the form

For financial assistance applications and supporting documents submitted in English, you can now utilize MyHealth to submit your documents. For all other application submissions, please submit the application by mail, e-mail, fax, or in person to the addresses below. Stanford Medicine will uphold the confidentiality and dignity of each patient. Any information submitted for consideration of financial assistance will be treated as protected health information under the Health Insurance Portability and Accountability Act (HIPAA). Information obtained from this financial application will not be used by Stanford Medicine in collection activities.

Stanford Medicine Health Care or
Stanford Medicine Partners
500 Pasteur Drive, Palo Alto, CA 94304

Customer Service Billing
Phone: (800) 549-3720
M-F 9:00AM – 5:00PM
stanfordhealthcare.org/financial-assistance

Stanford Medicine Tri-Valley
5555 W Las Positas Blvd, Pleasanton, CA 94588

Customer Service Billing
Phone: (800) 549-3720
M-F 9:00AM – 5:00PM
stanfordhealthcare.org/tri-valley/patients-and-visitors/financial-assistance.html

For more information regarding financial assistance or if you need help in completing the application, please contact the Customer Service Billing department or visit the Financial Assistance website for the facility where you are seeking care. You may obtain help for any reason, including disability and language assistance. By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

IMPORTANT INFORMATION REQUIRED WITH APPLICATION

Proof of Income (POI): Please provide a copy of **recent pay stubs** or **recent income tax returns** for all members of the patient family, as listed above. "Recent income tax returns" are tax returns that document a Patient's income for the year in which the Patient was first billed or 12 months prior to when the Patient was first billed. "Recent paystubs" are paystubs within a 6-month period before or after the Patient is first billed by the hospital, or in the case of preservice, when the application is submitted.

Please send your documents to the address specified below:

Type of Income	Acceptable documentation
Employment Income	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year (If claiming dependents, tax return is required) ***OR*** • Copy of two most recent consecutive paystubs (for applicant and co-applicant, if applicable)
Self-Employment	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year
Social Security/ Retirement	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year ***OR*** • Copy of Award Letter from Social Security Administration stating monthly payment ***AND*** Copy of monthly payment notification or Pension award letter.
Disability	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year ***OR*** • Copy of Award Letter from disability stating monthly disability payment
Unemployment	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year ***OR*** • Copy of Award Letter from unemployment stating daily, weekly, or monthly benefit amount
Spousal Support	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year showing this income. ***OR*** • Copy of court official letter stating monthly award amount
Rental Property Earned Income	• Copy of Schedule 1 Form
Investment Income	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year

Type of Income	Acceptable documentation
Proof of Dependents	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year
Proof of Enrollment (Student)	• Copy of current quarter/semester college or university registration/enrollment letter or report card. **AND** • Letter/e-mail from applicant explaining how monthly expenses are supported (if no income reported)
Sustainment Letter	• Letter/e-mail from applicant explaining how monthly expenses are supported (if no income reported)

The following types of documentation are not accepted for consideration of Stanford Medicine Financial Assistance:

- 1099 Form
- W-2 Form
- Bank Statement
- Tax Return Transcript
- List of Personal Expenses
- Copy of Check Payments

Every reasonable effort will be made to process your application promptly and once your application has been reviewed you will receive a letter confirming the outcome.

Return completed application to:

Stanford Medicine Health Care
Attention: Patient Financial Services
P.O. BOX 740715
Los Angeles, CA 90074-0715
Fax: (650) 493-8623
E-mail: FAA@stanfordhealthcare.org

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Stanford MEDICINE Health Care

FINANCIAL ASSISTANCE APPLICATION

DATE OF APPLICATION: _____

Please fill out all information completely. Please print all information.

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may verify the information and ask for additional information or proof of income.

1. FAMILY INFORMATION
(PLEASE PROVIDE NAMES OF ALL PEOPLE TO BE CONSIDERED FOR FINANCIAL ASSISTANCE)

Last Name	First Name	Middle Initial	Medical Record Number

If the patient is a minor, please list parent(s)/guardian(s) as applicant and co-applicant.

2. APPLICANT (GUARANTOR) INFORMATION

Relationship to Patient: ❑ Self ❑ Spouse/Domestic Partner ❑ Parent ❑ Other

Marital Status: ❑ Single ❑ Married ❑ Domestic Partner ❑ Divorced ❑ Separated ❑ Widow

If you marked "Married", please complete Section 3.

Last Name	First Name	Middle Initial	U.S. Citizen: ❑ Yes ❑ No

Date of Birth	No. of Dependents *(Other than self and co-applicant)*	Ages of Dependents	Home Phone ( )

Street Address	City	State	County	Zip

Current Employer	Street Address	City	State	Position

*** If you are not working, how long have you been unemployed?**

3. CO-APPLICANT INFORMATION

Relationship to Patient: ❑ Spouse ❑ Parent

Last Name	First Name	Middle Initial	U.S. Citizen: ❑ Yes ❑ No

Date of Birth	No. of Dependents *(other than self and co-applicant)*	Ages of Dependents	Home Phone ( )

Street Address	City	State	County	Zip

Current Employer	Street Address	City	State	Position

*** If you are not working, how long have you been unemployed?**

4. OTHER COVERAGE (ALL ANSWERS PERTAIN TO THE PATIENT)		*Check appropriate answer*
1.	Does the patient have health insurance? If yes, provide the following information: Health Insurance Name: _____ Insurance Phone Number: _____ Subscribers Name: _____ Members/Patients Identification Number: _____ Effective Date: _____ Group/Employer Name: _____ Group Number: _____	☐ Yes ☐ No
2.	Is the patient eligible for a state medical assistance program? If yes, provide the following information: Name of Program: _____ County: _____ Patient Identification Number: _____	☐ Yes ☐ No
3.	Is the patient being treated for injuries covered by Workers Compensation? If yes, please provide the following information: Name of Work Comp Carrier? _____ Adjusters Name: _____ Adjusters Phone Number: _____ Injury Date: _____ Claim/Case Number: _____	☐ Yes ☐ No
4.	Is the patient being treated for injuries covered by Third Party Liability such as an Auto Insurance Company? If yes, provide the following: Name of Auto Insurance or Attorney: _____ Auto Insurance or Attorney Phone Number: _____ Injury Date: _____ Claim/Case Number: _____	☐ Yes ☐ No
5.	Is the patient a Victim of Crime? If yes, provide the following information: Name of Case Worker: _____ Case Workers Phone Number: _____ Claim/Case Number: _____	☐ Yes ☐ No

5. INCOME INFORMATION

Monthly Income Sources	**Applicant**	**Co-Applicant**	**Combined Monthly Income (Applicant + Co Applicant)**
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal Support	$	$	$
Rental Property Income	$	$	$
Investment Income	$	$	$
Other[s] use these spaces	$	$	$
	$	$	$
Total Combined Monthly Income			

5. INSURED PATIENT WITH HIGH MEDICAL COST

❑ I hereby attest that I am an insured patient with high out-of-pocket medical expenses that amount to 10% or more of my family's income. I also acknowledge that Stanford Medicine Health Care reserves the right to request documentation to verify my medical expenses.

❑ Not Applicable (I am uninsured)

6. SIGNATURE

I certify that all information is valid and complete and hereby authorize Stanford Medicine Health Care to request and/or verify any of the above information as deemed necessary.

Applicant	**Date**	**Co-Applicant**	**Date**