Financial Assistance Application

Stanford Medicine Children's Health (SMCH) has a variety of options available for uninsured patients or patients with high medical costs.

Our financial assistance options include:

No Application Necessary

- ***Uninsured Patient Discount***
  Provides a discount off of the Gross Charges on your bill. Some services may be excluded.
- ***No Interest Payment Plans***
  Balances to be paid generally within 6 months.

Application Required

- ***Financial Hardship Discounts***
  Available to uninsured patients and insured patients with high medical costs. Discount at a rate comparable to our government insurance payers (Medi-Cal). Some services may be excluded.
- ***Charity Care (Full Financial Assistance)***
  100% waiver of patient portion due. Some services may be excluded.
- ***Extended No Interest Payment***
  Plans available to patients who qualify for financial assistance discounts.

Financial assistance is based on need. It might include a discount, or full financial aid. To be considered for any financial assistance, you must provide:

- A completed application
- Proof of income

Once we receive your completed application, we may screen whether you qualify for state or county programs. Applying for government programs is not a condition of receiving Financial Assistance.

Those who qualify for Financial Assistance may receive assistance with their hospital bills for services provided at Stanford Medicine Children's Health and physician bills for physicians employed by Stanford University.

Financial need discounting and full financial assistance is not available for all services.

In considering charity care, our first priority is to assist those who have had emergency services.

Our second priority is to assist those who have had or will have medically necessary non-emergency services and for whom Stanford Medicine Children's Health is the closest hospital to the patient's home or place of work.

Our third priority is to assist those who have had or will have medically necessary services and Stanford Medicine Children's Health is not the closest hospital to the patient's home or place of work but one or more of the following factors apply:

a. The patient has a unique or unusual condition which requires treatment at Stanford Medicine Children's Health, as determined by the Chief Medical Officer of SMCH.

b. The patient's care presents a teaching or research opportunity that would further the institution's teaching mission, as determined by the SMCH Chief Medical Officer and either the CFO or Chief Revenue Officer.

Important Information Required with Application

Proof of Income (POI): Kindly provide a copy of your **recent income tax return** or **recent pay stubs** for the patient and patient's family with your application. "Recent income tax return" means the tax return(s) that documents your Family Income for the year in which you were first billed or 12 months prior to when you were first billed. "Recent pay stubs" means the pay stubs within a 6-month period before or after when you are first billed or, in the case of pre-service, when you submit this application.

Below is a list of the acceptable POI documentation for each type of income.

Type of Income	Acceptable Documentation
Employment Income	• Copy of Individual tax return (Form 1040) for current tax year **OR** • Copy of two most recent paystubs
Self-Employment	• Copy of Individual tax return (Form 1040) for current tax year
Social Security / Retirement	• Copy of Individual tax return (Form 1040) for current tax year **OR** • Copy of Award Letter from Social Security Administration stating monthly payment; **AND** • Copy of monthly payment notification from Social Security Administration
Disability	• Copy of Individual tax return (Form 1040) for current tax year **OR** • Copy of Award Letter from disability stating monthly disability payment; **OR** • Copy of monthly payment notification from disability
Unemployment	• Copy of Individual tax return (Form 1040) for current tax year **OR** • Copy of Award Letter from unemployment stating weekly or monthly benefit amount; **OR** • Copy of monthly payment notification from unemployment
Spousal/Child Support	• Copy of Individual tax return (Form 1040) for current tax year **OR** • Copy of letter stating monthly award amount
Rental Property	• Copy of Individual tax return (Form 1040) for current tax year
Investment Income	• Copy of Individual tax return (Form 1040) for current tax year
Proof of Dependents	• Copy of Individual tax return (Form 1040) for current tax year

If you are unable to provide either of your recent income tax return or recent pay stubs, please provide an explanation as to why this information is not available. You may submit other forms of documentation of income, but SMCH does not require you to submit anything other than your most recent tax return or pay stubs. Missing documentation may delay the processing of your application and could result in a denial for assistance.

Where to Send Your Application and Proof of Income Documentation

Mail your completed application, with all the required supporting proof of income documentation, to the following address:

Stanford Medicine Children's Health
Attention: Patient Financial Assistance
4700 Bohannon Dr., 2nd Floor
Menlo Park, CA 94025-9840

Applications and documentation may also be sent by FAX to: **(650) 497-8610**

Or sent by email to: **PFA@stanfordchildrens.org.**

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

Please Print All Information

Date of application: _____

1. PATIENT INFORMATION | please provide names of all people to be considered for financial assistance

Last name	First name	Middle initial	Medical record number	Date of birth (mm/dd/yyyy)
Last name	First name	Middle initial	Medical record number	Date of birth (mm/dd/yyyy)
Last name	First name	Middle initial	Medical record number	Date of birth (mm/dd/yyyy)

If the patient is a minor, please list parent(s)/guardian(s) as applicant and co-applicant in Sections 2 and 3.

2. APPLICANT (PATIENT/GUARANTOR) INFORMATION

Relationship to patient	Marital status
◻ Self ◻ Spouse/Domestic Partner ◻ Parent ◻ Other: _____	◻ Single ◻ Married/Domestic Partner ◻ Divorced ◻ Separated

Last name	First name	Middle Initial

Date of birth (mm/dd/yyyy)	Number of dependents (other than self & co-applicant)	Ages of dependents	Home phone (xxx) xxx-xxxx	Cell phone (xxx) xxx-xxxx

Street address (Do not list PO box)	City	State	County	Zip

Current Employer	Street address, City, State	Position

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

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If you marked Yes to Married or Domestic Partner: Please complete Section 3.

3. CO-APPLICANT (GUARANTOR) INFORMATION

Relationship to patient				
☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other: _____				
Last name	First name			Middle initial
Date of birth (mm/dd/yyyy)	Number of dependents (other than self & co-applicant)	Ages of dependents	Home phone (xxx) xxx-xxxx	Cell phone (xxx) xxx-xxxx
Street address (Do not list PO box)	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 QUESTIONS | All answers pertain to the patient

		Check appropriate answer
1.	Is the patient applying for assistance with bills for: Past services: (Indicate dates: _____) Future services: (Indicate dates: _____)	☐ Yes ☐ No
2.	Does the patient have health insurance? **If yes, please provide the following information:** Health Insurance Name: _____ Subscribers Name: _____ Members/Patients Identification Number: _____ Group Number: _____ Group/Employer Name: _____ Effective Date: _____ Health Insurance Telephone Number: _____	☐ Yes ☐ No
3.	Is the patient eligible for a state medical assistance program? **If yes, please provide the following information:** Name of program: _____ County: _____ Patient Identification Number: _____	☐ Yes ☐ No

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4. OTHER COVERAGE QUESTIONS *(continued)* | All answers pertain to the patient

		Check appropriate answer
4.	Is the patient being treated for injuries covered by Workers Compensation? **If yes, please provide the following information:** Name of Workers Comp Carrier: _____ Adjusters Name: _____ Adjusters Phone Number: _____ Injury Date: _____ Claim/Case Number: _____	☐ Yes ☐ No
5.	Is the patient being treated for injuries covered by Third Party Liability such as an Auto Insurance Company? **If yes, please provide the following information:** Name of Auto insurance or Attorney: _____ Auto Insurance or Attorney Phone Number: _____ Injury Date: _____ Claim/Case Number: _____	☐ Yes ☐ No
6.	Is the patient a Victim of Crime? **If yes, please provide the following information:** Date of injury? _____ Name of Case Worker: _____ Case Workers Phone Number: _____ 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/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other(s) use these spaces	$	$	$
		Total Combined Monthly Income	$

6. IF YOU DO NOT HAVE MONTHLY INCOME, PLEASE DESCRIBE HOW YOU TAKE CARE OF YOUR MONTHLY EXPENSES. Use additional pages if necessary

7. Additional Information (Please use this space to provide any additional information that would help us understand your application).

8. SIGNATURE

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

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