# CHARITY CARE AND DISCOUNT PAYMENT PROGRAMS

## APPLICATION

***APPLICANTS MUST MEET THE FOLLOWING CRITERIA TO BE CONSIDERED FOR ELIGIBILITY TO THE CHARITY CARE OR DISCOUNT PAYMENT PROGRAMS:***

- Must not be eligible or have exhausted government / non-government payers
- Must not have any third-party liability
- Must apply for services received at Zuckerberg San Francisco General or Community Primary Care Clinic
- Must apply for services that have not already been discounted
- Must provide most recent quarter's pay stubs or most recent year tax return statement
- Must have a gross family household income at or below 500% federal poverty level for Charity Care consideration
- Must provide verification of qualified liquid assets for Charity Care consideration

***INSTRUCTIONS FOR APPLYING:***

- Complete and sign this application.
- Submit your application and verification documents.
  - Mail your application and verification documents to:

**Zuckerberg San Francisco General Hospital Billing Office**
**Patient Financial Assistance Department**
**1001 Potrero Ave.**
**Building 20, Ward 24, Room 2406**
**San Francisco, CA 94110**

- Call (628) 206-3275 for detailed information

### *APPLICANT INFORMATION*

| | |
|---|---|
| Last name: | First name: |
| Date of Birth: | Medical Record #: |

### *PERMANENT ADDRESS*

| | |
|---|---|
| Address: | City: |
| State: | Zip Code: |
| Country: | Telephone: |
| Cell Phone: | Email: |
| | |

### *TEMPORARY ADDRESS (if applicable)*

| | |
|---|---|
| Address: | City: |
| State: | Zip Code: |
| Country: | Telephone: |
| Cell Phone: | Email: |

### *ELIGIBILITY & SCREENING*

| | |
|---|---|
| What is your marital status? | ☐Married ☐Single ☐Widowed ☐Separated<br>☐Divorced ☐Domestic Partner |
| Do you have a medical insurance? | ☐Yes ☐No<br>***If yes, specify:***<br>***Provide Insurance card.*** |
| Do you have a disability expected to last 12 months? | ☐Yes ☐No |
| Do you have a pending application with Medi-Cal? | ☐Yes ☐No |
| Were you pregnant on the date of service? | ☐Yes ☐No N/A |
| Family Size (self, spouse and children under 21 yrs old) | # ______________ |
| Total family gross monthly income at the time of application: | $ _____________<br>***Provide most recent quarter (3 mos.) pay stubs or most recent year tax return.*** |
| Total assets at the time of application *(**excluding** retirement and deferred compensation plans:* | $ __________<br>***Provide financial statements most recent quarter (3 mos.) to date of application.*** |
| Identify all types of asset accounts held: | ☐Checking ☐Savings ☐Money Market<br>☐Certificate of Deposit ☐Brokerage ☐Mutual Fund<br>***Provide statements for all accounts held.*** |

*Application Information*

**I declare the answers given are true and correct to the best of my knowledge. I am uninsured or underinsured and have no third-party liability. I understand that the information I have provided will be verified. I understand that the information will be used to screen for eligibility to various Federal, State and County Programs. I understand that if my information is found to be false, I will be held responsible for the full amount of any fee for medical services received from Zuckerberg San Francisco General or the Community Primary Care Clinics.**

| *APPLICANT SIGNATURE:* | *DATE:* |
|---|---|

***PENDING DOCUMENTS – 30 DAY TIME LIMIT TO SUBMIT***

☐ 3 Months of Pay Stubs or Recent Tax Returns ☐ 3 Months of all bank statements

*Comments:*

***ELIGIBILITY DEPARTMENT DETERMINATION***

| | | |
|---|---|---|
| **Charity Program** | ☐Eligible | ☐Ineligible |
| **Discount Program** | ☐Eligible | ☐Ineligible |

**Denial Reasons:**

- ☐Non-compliance
- ☐Income over 500% FPL
- ☐Insured by government or non-government payer
- ☐Services were not received at ZSFG
- ☐Services received are already discounted
- ☐**Over 30 Days – Failed to provide requested verifications**
- ☐Other (specify) ________________________________________

**Eligibility determination made by:**

| | |
|---|---|
| Print Name: | |
| Signature: | Date: |
| Date sent to patient for final determination: | Financial Counselor Initials: |
| cc: Copy sent to patient | |

| Last name: | First name: |
|---|---|
| Date of Birth: | Medical Record #: |

***APPEALS PROCESS FOR DENIED APPLICATIONS*** *Determination • Appeals*

If you have been determined ineligible for the Charity Care and Discount Payment programs and wish to appeal your denial for eligibility, you have **15 business days** to appeal from the date of your eligibility determination. Please submit a copy of this completed application with your written statement below of the reason for your appeal request to:

**Zuckerberg San Francisco General Hospital • 1001 Potrero Avenue, Ward 15 • San Francisco, CA 94110**
**Attention: Jenine Smith, Patient Financial Services Manager**

*Reason for Appeal • Appeals Decision*

Date:

***Reason for appeal request:***

APPEALS DECISION

| | | |
|---|---|---|
| **Charity Program** | ☐Eligible | ☐Ineligible |
| **Discount Program** | ☐Eligible | ☐Ineligible |

**Decision made by:**

Print Name:

Signature:

Date: