**Please find enclosed the 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 United States residency is a requirement for financial assistance, Patient Financial Services will not solicit proof of citizenship or Legal Residency as demonstration of residency.** For more information about UCSF Health's Mission and Values, please visit: https://www.ucsfhealth.org/about/our-mission/.

## Charity Care Eligibility

You may qualify for 100% Financial Assistance if:
Your family income is at or below 400% of the Federal Poverty Level (FPL), **and**
The care you received is medically necessary.
For information regarding the Federal Poverty Level table please visit our Help Paying Your Bill page at: https://www.ucsfhealth.org/billing-and-insurance/help-paying-your-bill

Income verification is required for your Financial Assistance application to be processed. Please submit income documentation based on the type of income you receive. Applications missing required documentation will be returned or denied after 30 days.

**Acceptable proof of income based on your income type includes:**

**Employment Income**

- Copy of signed current-year federal income tax return (pages 1 and 2), **or**
- Copies of the most recent two (2) months of pay stubs,
  *(Documentation required for both applicant and co-applicant, if applicable)*

**Self-Employment Income**

- Copy of signed current-year federal income tax return (pages 1 and 2), **or**
- 1099 income statements
  *(Documentation required for both applicant and co-applicant, if applicable)*

**Social Security / Retirement Income**

- Copy of current Social Security benefit (award) letter, **or**
- Copy of pension or retirement benefit award letter

**Disability Income**

- Copy of disability benefit award letter indicating the monthly benefit amount, **or**
- Copy of signed current-year federal income tax return (pages 1 and 2)
  *(If applicable to applicant and/or co-applicant)*

**Unemployment Income**

- Copy of unemployment benefit award letter indicating weekly or monthly benefit amount

## Online Submission

For fastest assistance, please apply for Financial Assistance on MyChart. Please visit: https://www.ucsfhealth.org/mychart.

## Paper Submission

For paper applications, please scan and return the completed Financial Assistance Application, together with the supporting documents, by email to FinancialAssistance@ucsf.edu.

If you are submitting paper documents by mail, please remember to include the supporting documents listed above and mail the application and supporting documents to:

**UCSF Health Patient Financial Services**
**Attn: Financial Assistance & Charity Care Unit**
**6425 Christie Avenue Suite 500**
**Emeryville, CA 94608**

## Additional Questions

If you have any further questions and/or concerns, please contact Patient Financial Services at (866) 433-4035. (8 am to 4 pm Pacific Time, Monday – Friday, excluding holidays).

## Services not covered by Financial Assistance

Services that are not medically necessary are not eligible for financial assistance. This includes, but is not limited to, elective services such as acupuncture, cosmetic procedures, infertility or reproductive health services,, and certain ophthalmology services and audiology services that are not deemed medically necessary..

## Important Notice

This application is used solely to apply for the UCSF Health Financial Assistance (Charity Care) Program.
Patients who are approved for Financial Assistance receive a 100 percent adjustment of eligible charges, based on established eligibility criteria.
No application is required for uninsured patients to receive the standard self-pay discount. Uninsured self-pay discounts are applied automatically and are separate from the Financial Assistance Program.

UCSF Health

# Financial Assistance Application

| *1. PATIENT INFORMATION* | | | | |
|---|---|---|---|---|
| **Last Name** | **First Name** | **Initial** | **Guarantor/Account No.** | **Med. Record No.** |
| | | | | |

| *2. APPLICANT INFORMATION* | **RELATIONSHIP TO PATIENT** ☐ **Self** ☐ **Spouse** ☐ **Parent** **Other** _____ | **Marital Status** ☐ Married ☐ Single ☐ Separated **IF MARRIED, SECTION 3 MUST BE COMPLETED** |
|---|---|---|

| **Last Name** | **First Name** | **U.S. Citizen** ☐ Yes ☐ No |
|---|---|---|

| **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** ☐ **Spouse** ☐ **Parent** **Other** _____ |
|---|---|

| **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: (*Unemployment, Disability, Pension, etc*.) | $ | $ | $ |
| | | **Total Combined Monthly Income** | | $ |

***5. Medical Expenses Last 12 months:***

**UCSF Accounts**

| **Account ID** | **Guarantor** | **Amount Paid** | **Remaining Balance** |
|---|---|---|---|
| 1. | | | $ |
| 2. | | | $ |
| 3. | | | $ |
| **Medical Expense Outside UCSF** | | | |
| **Medical or Hospital Provider** | **Dates of Service** | **Amount Paid** | **Remaining Balance** |
| 1. | | $ | $ |
| 2. | | $ | $ |
| 3. | | $ | $ |

If you need to detail additional information, please attach a sheet to this application listing additional medical expenses.

***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)***

**<u>From both applicant & co-applicant</u>**

**Employment Income:**

Copy of signed current year's Income Tax Return page 1 and 2 (for both applicant & co-applicant) or Copy of most recent (2 months) pay stubs for both applicant & co-applicant **or** current year W2 form(s) for applicant and co-applicant if applicable

**Self-Employment Income:**

Copy of signed current year's Income Tax Return, page 1 and 2 (for both applicant & co-applicant or 1099 earning statements for both applicant & co-applicant

**Social Security/Retirement Income:**
Copy of current Social Security Allotment letter or copy of pension award letter.

**Disability Income :**
Copy of disability award letter stating monthly payment or current year's Income Tax Return page 1 and 2 (for both applicant & co-applicant)

**Unemployment Income:**
Copy of award letter from unemployment stating weekly or monthly benefit amount

***7. COMMENTS***

Enter any additional information relevant to your request not reflected in this application.

UCSF Health

***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** |
|---|---|---|---|
| _____ | | _____ | |

Rev: 1/4/2026