San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Department of Public Health
Zuckerberg San Francisco General Hospital
Laguna Honda Hospital and Rehabilitation Center
Community Primary Care Clinics
Population Health Division
Behavioral Health Services

CHARITY CARE PROGRAM AND DISCOUNT PAYMENT PROGRAMS APPLICATION

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

- Patients may only apply for services received at Zuckerberg San Francisco General Hospital, Community Primary Care Clinics, Laguna Honda Hospital, Population Health Division, or Behavioral Health Services.
- Patients may only apply for services that have not already been discounted by the hospital OB or VIP Package Programs.
- Patients must make every reasonable effort to provide documentation of income and health benefits coverage. Failure to provide information that is reasonable and necessary may be considered in making a determination of eligibility.
- Patients, guarantors or subscribers who receive insurance payments for services received must surrender payments to the San Francisco Health Network to be eligible for financial assistance.

CHARITY CARE PROGRAM – ADDITIONAL ELIGIBILITY AND INCOME VERIFICATION

- Patients must also cooperate with eligibility screening and applying for Medicare, Medi-Cal, or other eligible coverage.
- Patients must have a gross family household income at or below 138% federal poverty level and provide recent tax returns or pay stubs as verification.
    - Recent tax returns are tax returns from the most recent year from the application date. Recent pay stubs are paystubs within three months prior to the application date.
    - Recent tax returns may also include tax returns which 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 may also include paystubs within a 6-month period before or after the patient was first billed by the hospital.
- Patients qualified for charity care have their billed payment responsibility waived.

DISCOUNT PAYMENT PROGRAM - ADDITIONAL ELIGIBILITY AND INCOME VERIFICATION

- Patients must also cooperate with eligibility screening for Medicare, Medi-Cal, or other coverage.
- Patients must have a gross family household income above 138% FPL and provide recent tax returns or pay stubs as verification.
    - Recent tax returns are tax returns which 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 was first billed by the hospital.

- Recent tax returns may also include tax returns from the most recent year from the application date. Recent pay stubs may also include paystubs within three months prior to the application date.

- Patients who only qualify for discount payment program eligibility receive less financial assistance than what may be available to them under the charity care program.

INSTRUCTIONS FOR APPLYING:

Mail a complete application and income verification. Applications are requested within one year from date of service. Applications that remain incomplete for more than 30 calendar days will be closed as inactive.

To apply for Hospital and clinic services, mail an 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 the Patient Financial Assistance Department at (628) 206-3275 for application assistance.

Hospital and clinic service locations include Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG), Specialty Outpatient Clinics, Community Primary Care Clinics, Laguna Honda Hospital and Rehabilitation Center, and the Population Health Division.

To apply for Behavioral Health Services, mail an application and verification documents to:

BHS Program Member Services Department
1360 Mission St, 2nd Floor
San Francisco, CA 94103

Call the BHS Member Services Department at (888) 246-3333 for application assistance.

PATIENT INFORMATION		
Last name:	First name:	
Date of Birth:	Medical Record #:	Account #(s):

GUARANTOR INFORMATION (If different than the patient)	
Last name:	First name:

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 ☐Divorced ☐Domestic Partner
Do you have any medical insurance?	☐Yes ☐No **If yes, specify all:** **Provide Insurance card(s).**
Do you have or expect to have any claims against any third party? A third party is responsible for injury, medical, loss in which there may be a settlement.	☐Yes ☐No **If yes, specify all:**
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, dependent children under 21 years old, and dependent disabled children of any age whether living at home or not)	# _____
Total family gross monthly income:	$ _____ **Provide recent pay stubs or tax return.**

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 Hospital and Specialty Outpatient Clinics, Community Primary Care Clinics, Laguna Honda Hospital, Population Health Clinic, or Behavioral Health Services.

APPLICANT PRINT NAME:

APPLICANT SIGNATURE: DATE:

Relationship to Patient: