COUNTY OF SANTA CLARA
Health System

FINANCIAL ASSISTANCE APPLICATION

Instructions

For free help completing this application, please contact Patient Financial Services by phone at **1-866-967-4677 (TTY: 711)** (8am to 4:30pm, Monday to Friday) or in person at 770 S. Bascom Avenue, San José, CA 95128 (8am to 4:30pm, Monday to Friday).

For more information about financial assistance options, please visit us online at **scvh.org/bill-help.**

Please fill out this entire application and return it to Patient Financial Services:

- **by fax** at 1-408-494-7848
- **by mail or in person** at 770 S. Bascom Avenue, San José, CA 95128, or
- **by e-mail** at HHSVCApp@hhs.sccgov.org

  Note: If you choose to e-mail us, we recommend that you encrypt your message to protect the privacy and security of your personal documents.

You must also **provide at least one of each** of the following documents in support of your application:

1. **Proof of identity** (for example: driver's license, passport, government-issued ID, work or school ID, or birth certificate plus gym or other ID); and
2. **Proof of income** (recent pay stubs or income tax returns).

If you are a Santa Clara County resident and want to apply for long-term financial assistance lasting up to one year, please also submit proof of residency (for example: rental contract/lease/mortgage, utility bill, vehicle registration, or declaration of homelessness). Proof of residency is not required to qualify for charity care or a discount payment.

Eligibility for healthcare coverage programs other than the County's charity care and discount payment program (known as the Healthcare Access Program or HAP) may require additional documentation. Applicants will be instructed which documents to provide, as necessary. Patients who only apply for a discount payment under the HAP may receive less financial assistance than what may be available to them under the HAP's charity care criteria.

To obtain this application and related information in another language or in an accessible alternative format—including, but not limited to, large print, braille, audio, and electronic formats that are accessible and may be read by a screen reader in a logical reading order—please contact Patient Financial Services at 1-866-967-4677 (TTY: 711).

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Background Information

Legal Name (Last, First, Middle):	
Gender:	**Preferred language:**
E-mail address:	**☐ Check here to consent to receive updates about this application by secure e-mail**
Phone number: **( ) -**	**Mailing address (including city, state, zip code):**
U.S. Citizen? ☐ Yes ☐ No	**Resident of Santa Clara County? ☐ Yes ☐ No**
U.S. Veteran? ☐ Yes ☐ No	**Lawful Permanent Resident / Green Card Holder / Employment Authorization Document Holder?** **☐ Yes ☐ No**
Mother's Maiden Name:	**If yes, for how long? _____Years _____ Months**
Applicant's work status: ☐ Employed ☐ Self-Employed ☐ N/A **Most recent workplace name & phone number: _____ / ( ) -** **Dates of most recent employment/self-employment: ___ /___ /___ to ___ /___ /___**	
Spouse's/domestic partner's work status: ☐ Employed ☐ Self-Employed ☐ N/A **Most recent workplace name & phone number: _____ / ( ) -** **Dates of most recent employment/self-employment: ___ /___ /___ to ___ /___ /___**	
Disability expected to last 12 months or longer? **☐ Yes, me ☐ Yes, my spouse/domestic partner ☐ No**	

Household Status

Please list all members of your family below, including yourself, your spouse or domestic partner, and dependent children under age 21, or any age if disabled (whether living at home or not). Please also check the box (☐) if you claim the person on your tax return.

Legal Name (Last, First, Middle)	Date of Birth (Month/Day/Year)	Relation to You	Social Security Number (if applicable)
(☐)			
(☐)			
(☐)			
(☐)			
(☐)			
(☐)			

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Healthcare Insurance and Access

Do you have health insurance (including, but not limited to, Medicare, Medi-Cal, a Covered California plan, employer-sponsored coverage, and/or other third-party coverage for healthcare-related expenses)? ☐ Yes ☐ No
Name(s) of insurance(s):
Insurance contact number(s): ( ) - | ( ) -
If you were injured, were your injuries caused by a third party (such as during a car accident or a slip and fall)? ☐ Yes ☐ No
Do you have other insurance that may apply (like an auto policy)? ☐ Yes ☐ No
Did you or your family pay any out-of-pocket healthcare expenses (such as copayments, coinsurance, deductibles, and bills not covered by insurance) in the past 12 months? ☐ Yes ☐ No **If yes, please state the total amount paid: $ _____**
(If applicable) I have a primary care physician at: ☐ CSCHS ☐ a community clinic
(If applicable) Name of primary care physician:

Current Monthly Income

Please fill out the below table using **total gross income (i.e., before tax) numbers for all members of your family** (including yourself, your spouse or domestic partner, and dependent children under age 21, or any age if disabled, whether living at home or not).

Monthly Income Source	**Patient**	**Spouse**	**Other**	***DO NOT FILL OUT – FOR OFFICE USE ONLY***
1. Income from work (salary, wages, cash earnings, and other compensation)	$	$	$	
2. Income from operating a business (if self-employed)	$	$	$	
3. Income from interest and dividends	$	$	$	Total gross monthly income:
4. Income from real estate or personal property	$	$	$	
5. Income from Social Security	$	$	$	$ _____
6. Other income (specify: _____)	$	$	$	
7. Alimony / child support payments received	$	$	$	Family Size:
8. Alimony / child support payments PAID	$	$	$	_____
Total income (add lines 1 through 7 above) minus any alimony / child support payments PAID (line 8)	**$**			FPL Level: _____

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Other Information

If there is additional information about your financial assistance application that you want us to know, please include it in the box below or attach a separate document. If not, please leave this box blank.

Declaration and Signature

I declare under penalty of perjury that the information I have provided in this application is true and correct to the best of my knowledge, and that where I did not already know the answer to any question, I made every reasonable attempt to confirm the answer with someone who did know. I understand that I must inform the County of Santa Clara Health System (CSCHS) of any change in my residency, financial status, household size, and/or eligibility for insurance coverage within 60 days of when the change occurs or at the next point of service, whichever is earlier. I consent to release my health record information in order to receive collaborative healthcare with providers that contract with the County of Santa Clara, as well as to the County of Santa Clara Social Services Agency for purposes of determining Medi-Cal eligibility and sharing information about my Medi-Cal status. I authorize CSCHS to verify any of the information in this application as it deems necessary.

_____ _____

Date Signature