Stanford MEDICINE
Health Care

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

This is an application for financial assistance (also known as charity care) at Stanford Medicine. For purposes of financial assistance, "Stanford Medicine" includes Stanford Medicine Health Care, Stanford Medicine Tri-Valley, and Stanford Medicine Partners. You may qualify for financial assistance based on your family size and income, even if you have health insurance. Financial assistance may not cover all health care costs, including services provided by other organizations. Assistance is awarded if you meet the financial assistance guidelines which includes if your household income is 400% or less of the Federal Poverty Level. Consideration for future services will be based on medical necessity and catastrophic costs.

Stanford Medicine has a variety of options available for uninsured or underinsured patients. Our financial assistance options include:

No Application Required

- **Uninsured Discounts –** *Some services may be excluded.*
- **No Interest Payment Plans –** *Balances to be paid generally within 6-12 months.*

Application Required

- **Full Financial Assistance –** *100% of patient portion due. Some services may be excluded.*
- **Extended No Interest Payment Plans –** *Balances to be paid generally within 12-18 months.*

In order for your application to be processed, you must:

- Provide us information about your family; fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- Provide us information about your family's gross monthly income (income before taxes and deductions)
- Attach additional information if needed (for example, sustainment letter validating information)
- Sign and date the form

For English financial assistance applications and supporting documents, you can now utilize MyHealth to submit your documents. For all other application submissions, continue to submit by mail, e-mail, fax, or in person. Stanford Medicine will uphold the confidentiality and dignity of each patient. Any information submitted for consideration of financial assistance will be treated as protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

Stanford Medicine Health Care or Stanford Medicine Partners 500 Pasteur Drive Palo Alto, CA 94304 **Customer Service Billing** Phone: (800) 549-3720 M-F 9:00AM - 5:00PM stanfordhealthcare.org/financial-assistance	**Stanford Medicine Tri-Valley** 5555 W Las Positas Blvd Pleasanton, CA 94588 **Customer Service Billing** Phone: (800) 549-3720 M-F 9:00AM - 5:00 PM stanfordhealthcare.org/tri-valley/patients-and-visitors/financial-assistance.html

For more information regarding financial assistance or if you need help in completing the application, please contact the Customer Service Billing department or visit the Financial Assistance website for the facility where you are seeking care. You may obtain help for any reason, including disability and language assistance. By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

IMPORTANT INFORMATION REQUIRED WITH APPLICATION

Proof of Income (POI): Please provide any relevant POI documentation that applies to your current financial situation. Failure to submit the required supporting documentation may delay the processing of your application and may further result in denial of financial assistance. Please send your documents to the address specified below:

Below is a listing of the POI documentation that is required for consideration of SHC Financial Assistance.	
Type of Income	**Required documentation**
Employment Income	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year (If claiming dependents, tax return is required) *or* • Copy of two most recent consecutive paystubs (for applicant and co-applicant, if applicable)
Self-Employment	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year
Social Security/Retirement	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year *or* • Copy of Award Letter from Social Security Administration stating monthly payment *and* • Copy of monthly payment notification or Pension award letter.
Disability	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year *or* • Copy of Award Letter from disability stating monthly disability payment
Unemployment	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year *or* • Copy of Award Letter from unemployment stating daily, weekly, or monthly benefit amount
Spousal Support	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year showing this income. *or* • Copy of court official letter stating monthly award amount
Rental Property Earned Income	• Copy of Schedule 1 Form
Investment Income	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year
Proof of Dependents	• Copy of Individual tax return (Form 1040, Page 1 and 2 only) for current tax year
Proof of Enrollment (Student)	• Copy of current quarter/semester college or university registration/enrollment letter or report card. *and* • Letter/e-mail from applicant explaining how monthly expenses are supported (if no income reported)
Sustainment Letter	• Letter/e-mail from applicant explaining how monthly expenses are supported (if no income reported)

The following types of documentation are not accepted for consideration of Stanford Medicine Financial Assistance:

- 1099 Form
- W-2 Form
- Bank Statement
- Tax Return Transcript
- List of Personal Expenses
- Copy of Check Payments

Every reasonable effort will be made to process your application promptly and once your application has been reviewed you will receive a letter confirming the outcome. Completed applications may be mailed with the required supporting documentation to:

Stanford Medicine Health Care
Attention: Patient Financial Assistance
P.O. BOX 740715
Los Angeles, CA 90074-0715

Applications may also be faxed to (650) 493-8623 or e-mailed to FAA@stanfordhealthcare.org for faster processing.

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FINANCIAL ASSISTANCE APPLICATION

DATE OF APPLICATION: _____

Please fill out all information completely. Please print all information.

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may verify the information and ask for additional information or proof of income.

1. FAMILY INFORMATION
(PLEASE PROVIDE NAMES OF ALL PEOPLE TO BE CONSIDERED FOR FINANCIAL ASSISTANCE)

Last Name	First Name	Middle Initial	Medical Record Number

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

2. APPLICANT (GUARANTOR) INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other

Marital Status: ☐ Single ☐ Married ☐Domestic Partner ☐ Divorced ☐ Separated ☐ Widow
If you marked "Married", please complete Section 3.

Last Name	First Name	Middle Initial	U.S. Citizen: ☐ Yes ☐ No

Date of Birth	No. of Dependents *(Other than self and co-applicant)*	Ages of Dependents	Home Phone ( )

Street Address	City	State	County	Zip

Current Employer	Street Address	City	State	Position

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

3. CO-APPLICANT INFORMATION

Relationship to Patient: ☐ Spouse ☐ Parent

Last Name	First Name	Middle Initial	U.S. Citizen: ☐ Yes ☐ No

Date of Birth	No. of Dependents *(other than self and co-applicant)*	Ages of Dependents	Home Phone ( )

Street Address	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 (ALL ANSWERS PERTAIN TO THE PATIENT)		*Check appropriate answer*
1.	Does the patient have health insurance? If yes, please provide the following information: Health Insurance Name:_____ Insurance Phone Number:_____ Subscribers Name: _____ Members/Patients Identification Number:_____ Effective Date:_____ Group/Employer Name: _____ Group Number: _____	☐ Yes ☐ No
2.	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
3.	Is the patient being treated for injuries covered by Workers Compensation? If yes, please provide the following information: Name of Work Comp Carrier:_____ Adjusters Name:_____ Adjusters Phone Number:_____ Injury Date:_____ Claim/Case Number:_____	☐ Yes ☐ No
4.	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
5.	Is the patient a Victim of Crime? If yes, please provide the following information: Name of Case Worker:_____ Case Workers Phone Number:_____ Claim/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 Support	$	$	$
Rental Property Income	$	$	$
Investment Income	$	$	$
Other[s] use these spaces	$	$	$
	$	$	$
		Total Combined Monthly Income	$

7. SIGNATURE

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

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

Return completed application to:	**Stanford Medicine Health Care** **Attention: Patient Financial Services** **P.O. BOX 740715** **Los Angeles, CA 90074-0715** **Fax: (650) 493-8623** **E-mail: FAA@stanfordhealthcare.org**