UCSF Health

UCSF MEDICAL CENTER

Financial Assistance Application

Please find enclosed the Financial Assistance Application.

UCSF Medical Center 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 Medical Center 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 to determine eligibility for Financial Assistance. Please submit copies of 2 months recent pay stubs or your signed recent federal income tax return. If additional information is needed to process your application, UCSF Health will contact you. Applications that remain incomplete will be denied after 30 days. Patients may submit the missing documentation for reconsideration of their Financial Assistance application..

Acceptable Proof of Income

Please submit one of the following for the applicant and, if applicable, the co-applicant:

- Copies of the 2 months recent pay stubs, or
- A signed recent federal income tax return (pages 1 and 2).

If neither is available, UCSF Medical Center may accept, but does not require, other documentation that reasonably verifies income, including:

- Social Security or retirement benefit award letters;
- Disability benefit award letters;
- Unemployment benefit award letters;
- 1099 income statements; or
- Other documentation demonstrating current income.

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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 Medical Center 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 Medical Center 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.

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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.

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**

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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	**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.			$

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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

Applications that remain incomplete may be denied after 30 days, with the option to submit the missing documentation for reconsideration of their Financial Assistance application.

(Bank statements will not be accepted as proof of income)

From applicant & co-applicant if applicable

Employment Income:

Copy of signed recent Income Tax Return page 1 and 2 (for both applicant & co-applicant) or copy of recent (2 months) pay stubs for both applicant & co-applicant

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7. COMMENTS

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

8. SIGNATURE AND DATE (REQUIRED OF APPLICANT AND CO-APPLICANT)

I certify that the information provided in this application is true, complete, and accurate to the best of my knowledge. I authorize UCSF Health to review the information necessary to determine my eligibility for Financial Assistance. I understand that if additional information is needed, UCSF Health will contact me. Applications that remain incomplete may be denied with the option to submit the missing documentation for reconsideration of my Financial Assistance application. I understand that I may be required to submit a new application for future services. I agree to notify UCSF Health of any changes to my financial circumstances that may affect my eligibility for Financial Assistance.

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