Dear UCSF Health Patient or Patient Representative:

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

Income verification must be included for the application to be processed. Please provide all information to avoid delays in processing. Application will be returned if supporting documentation is missing. Acceptable proof of income includes:

- ❑ Copy of most recent (2 months) pay stubs for both applicant & co-applicant.
- ❑ Copy of current year W-2 or 1099 earnings statements for both applicant & co-applicant.
- ❑ Copy of signed current year's Income Tax Return (for both applicant & co-applicant)
- ❑ Copy of current Social Security Allotment letter and/or other proof of income
- ❑ ** Bank statements will not be accepted as proof of income.

Updated Income Verification Requirements Related to COVID-19:

We understand that many in our community may be impacted by the financial hardship caused by COVID-19. We are here to help.

- If your current year ( )'s Income Tax Return has not been filed yet, please provide the previous year ( )'s Tax Return.
- If you have filed for unemployment benefits, please provide your monthly (or bi-weekly) statement showing the current benefit amount that you are receiving.
- If you have other financial hardships due to COVID-19, please provide an explanation using the "Comments" section of the application.

You may return the completed Financial Assistance Application to:

UCSF Health Patient Financial Services
Attn: Financial Assistance & Charity Care Unit
6425 Christie Avenue Suite 300
Emeryville, CA 94608

Or email to FinancialAssistance@ucsf.edu

If you have any further questions and/or concerns, please contact Patient Financial Services at (866) 433-4035.

Note:
Services deemed as not medically necessary or experimental are not eligible for financial assistance. Self pay patients (no insurance coverage) must provide a Notice of Action Letter from Medi-Cal Indicating that he/she applied but was deemed ineligible.

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**			
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** ☐ Self ☐ Spouse ☐ Parent ☐ Other _____
Last Name	**First Name**	**Initial**	**Relationship to Applicant**
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**	

UCSF Health

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. ASSETS (To list additional assets, use back of this application)			
Checking/Money Market/Savings Accounts:			
Bank Name:	**Branch/Address**		**Monthly Balance/ Value**
1.			$
2.			$
Other Cash Assets:			$
		Total Asset Value	$

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)

From both applicant & co-applicant

- ☐ Copy of most recent (2 months) pay stubs for **both** applicant & co-applicant.
- ☐ Copy of current year or previous year's W-2 or 1099 earnings statements for **both** applicant & co-applicant.
- ☐ Copy of **signed** current year's or previous year's Income Tax Return
- ☐ Copy of Social Security Allotment letter and/or other proof of income **(section 4)**

7. COMMENTS

Enter any additional information relevant to your request not reflected on 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: 11/08/2019