COUNTY OF SANTA CLARA
Health System

FINANCIAL ASSISTANCE APPLICATION

VMC/OCH/SLRH Medical Record Number:

APPLICANT INFORMATION

1. Resident of Santa Clara County? □ Yes / □ No	2. Gender	3. Legal Name (*Last, First, Middle*)	4. Mother's Maiden Name	5. Spouse / Domestic Partner	6.Preferred Language?

7. Address	Zip	8. Phone 1) 2)	9. Email Address

10. SSN (PATIENT)	11. SSN (SPOUSE / DOMESTIC PARTNER)	12. U.S. Citizen? □ Yes / □ No	13. Have permanent residency status? □ Yes / □ No If yes, How long? Length:_____Years_____ Months	14. U. S. Veteran? □ Yes / □ No

FAMILY HOUSEHOLD STATUS

15. List the names of all members in your household and family, and their relationship to you. Please Add yourself. Please check the box (□) if you claim them on your tax return form.

NAME	Date of Birth (Month/Day/Year)	RELATION	NAME	Date of Birth (Month/Day/Year)	RELATION
(□)			(□)		
(□)			(□)		
(□)			(□)		

MOST RECENT EMPLOYMENT AND OCCUPATION

16. Patient's Employer:	17. Contact Phone Number	18. If Self-Employed, Name of Business
19. Spouse's Employer:	20. Contact Phone Number	21. If Self-Employed, Name of Business

22. Start Date:	23. End Date:	24. Job is Current: □ Yes / □ No	25. Have a Disability expected to last at least 12 months? □ Yes / □ No

INSURANCE COVERAGE INFORMATION

26. Have Health Insurance: □ Yes / □ No Name of Insurance:	Insurance Contact Number:	27. Were your injuries caused by a third party (such as during a car accident or slip and fall)? □ Yes / □ No (	28. Do you have other insurance that may apply such as an auto policy)? □ Yes/ □ No

CURRENT MONTHLY INCOME

	Monthly Income Sources	Patient	Spouse	Other
29a)	**GROSS** PAY *(tax & other deductions)*	$	$	$
29b)	Income from Operating Business (if Self-Employed)	$	$	$
29c)	Other Income:	$	$	$
29d)	Interest and Dividends	$	$	$
29e)	From Real Estate or Personal Property	$	$	$
29f)	Social Security	$	$	$
29g)	Other (specify):	$	$	$
29h)	Alimony or Support Payments Received	$	$	$
29i)	Add the amounts in the right column from line (29a) through (29h)	$	$	$
29j)	Alimony or Support Payments Paid	$	$	$
29k)	Subtract line (29j) from line (29i). This is your Current Monthly Income.	$	$	$
29l)	**TOTAL INCOME FROM ALL COLUMNS line 29k**	**$**		

30. Do you have a Primary Care Physician (PCP) at a community clinic?
If Yes, what is the name of your PCP (Primary Care Physician)? _____
Do you have a Primary Care Physician (PCP) at VMC?
If Yes, what is the name of your PCP (Primary Care Physician)?_____.

For Office Use Only

Total Income Gross: _____

Frequency

□ Weekly □ Bi-Weekly

□ Semi-Monthly □ Monthly

Family Size: _____ Final FPL: _____

SIGNATURE

I declare under penalty of perjury that the information I have provided above is true and complete. I understand 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 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 Santa Clara County Social Services Agency (SCCSSA) for the purpose of determining eligibility for Medi-Cal and sharing information about my Medi-Cal status. I authorize CSCHS to request a credit report and/or to verity any of the above information as it deems necessary.

SIGNATURE_____ **Date** _____

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REMEMBER: To qualify for charity care or discounted care under the County of Santa Clara Health System's (CSCHS) Healthcare Access Program (HAP), you must make all reasonable efforts to submit your Financial Assistance Application to CSCHS within 180 days of being sent your first billing statement for a particular episode of care. **If you submit your application after this 180-day timeframe, you must explain why there is good cause for the delay using the space below.** You may submit additional documents in support of your explanation. CSCHS may also contact you to request additional information. If you have questions or need help filling out this form, please contact the Patient Access Department by phone at (866) 967-4677 (TTY: 711) (8am to 5pm, Monday to Friday) or in-person at 770 S. Bascom Avenue, San José, CA 95128 (8am to 4:30pm, Monday to Friday).

I affirm that the information I have provided is true and correct.

_____ _____

Date Signature