COUNTY OF SANTA CLARA
Health System

Healthcare Access Program (HAP) – Appeal Form

Instructions

If the County of Santa Clara Health System (CSCHS) denied your Financial Assistance Application, or if you believe you qualify for a larger discount under CSCHS's Healthcare Access Program (HAP), you may appeal by:

1. Filling out the second page of this form; and
2. Submitting your completed form (and any documents supporting your appeal) to one of the following addresses within **30 days** of the denial or decision you disagree with:

By Mail	**In Person Drop-Off**
CSCHS Patient Business Services 5750 Fontanoso Way, 1st Floor San José, CA 95138 Attention: Revenue Cycle Director	CSCHS Patient Access Department 770 S. Bascom Avenue San José, CA 95128

Your appeal should **explain why you disagree** with the initial denial or decision you received from CSCHS. For example, if you think we made a mistake or there is additional information we should consider, please let us know. As a reminder, you can find the full HAP policy listing all eligibility requirements online at: https://health.sccgov.org/healthcare-access-program.

You may submit supporting documents along with your completed appeal form. CSCHS may also contact you to request that you submit additional documents and/or information about your appeal.

CSCHS will make a decision on your appeal within 30 days of receiving your completed appeal form. If the initial denial or decision is upheld, you may submit a second appeal by completing another copy of this form and submitting it (and any supporting documents) to the following address within **30 days** of the denial of your first appeal:

By Mail	**In Person Drop-Off**
CSCHS Finance Department 2325 Enborg Lane, Suite 360B San José, CA 95128 Attention: Chief Financial Officer	CSCHS Patient Access Department 770 S. Bascom Avenue San José, CA 95128

CSCHS will make a decision on any second appeal within 30 days of receiving your completed appeal form. The decision on any second appeal will be final.

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).

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Required Information

Please **complete all the fields below** before submitting this appeal form to CSCHS. Providing incomplete information may result in a delay or denial of your appeal.

Patient or Guarantor Name (Last, First, Middle):	
Date of Birth (month/day/year):	**Medical Record Number (if known):**
E-mail Address:	☐ **Check here to consent to receive communications regarding this appeal by secure e-mail**
Phone Number:	**Mailing Address:**
Date of Denial or Decision You Disagree With:	
Explain Why You Disagree with the Denial or Decision and What Relief You Are Requesting (if you need more space, please submit additional pages with this form):	

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

_____ _____

Date Signature

Last Updated: January 2023