

## FINANCIAL ASSISTANCE APPLICATION

#### <u>Instructions</u>

For free help completing this application, please contact Patient Financial Services by phone at 1-866-967-4677 (TTY: 711) (8am to 4:30pm, Monday to Friday) or in person at 770 S. Bascom Avenue, San José, CA 95128 (8am to 4:30pm, Monday to Friday).

For more information about financial assistance options, please visit us online at scvh.org/bill-help.

Please fill out this entire application and return it to Patient Financial Services:

- **by fax** at 1-408-494-7848
- by mail or in person at 770 S. Bascom Avenue, San José, CA 95128, or
- **by e-mail** at HHSVCApp@hhs.sccgov.org

<u>Note</u>: If you choose to e-mail us, we recommend that you encrypt your message to protect the privacy and security of your personal documents.

You must also provide at least one of each of the following documents in support of your application:

- 1. **Proof of identity** (for example: driver's license, passport, government-issued ID, work or school ID, or birth certificate plus gym or other ID);
- 2. **Proof of income** (for example: recent pay stubs, income tax returns, Social Security award letter, award letters for other benefits, military benefits statements, and/or rental income receipts, as applicable); and
- 3. **Proof of residency** (for example: rental contract/lease/mortgage, utility bill, vehicle registration, or declaration of homelessness).

Eligibility for some healthcare coverage programs may require additional documentation. If more documents are required, you will be instructed which documents to provide.

County residents who only seek to qualify for a partial discount under the CSCHS Healthcare Access Program (HAP) (i.e., self-pay or high medical cost patients with incomes above 400% but below 650% of the Federal Poverty Level) only need to submit recent pay stubs or income tax returns as proof of income.

To obtain this application and related information in another language or in an accessible alternative format—including, but not limited to, large print, braille, audio, and electronic formats that are accessible and may be read by a screen reader in a logical reading order—please contact Patient Financial Services at 1-866-967-4677 (TTY: 711).



# **Background Information**

Legal Name (Last, First, Middle):				
Gender:	Preferred language:			
E-mail address:	☐ Check here to consent to receive updates about this application by secure e-mail			
Phone number:	Mailing address (including city, state, zip code):			
( )				
U.S. Citizen? ☐ Yes ☐ No	Resident of Santa Clara County? ☐ Yes ☐ No			
U.S. Veteran? ☐ Yes ☒ No	Lawful Permanent Resident / Green Card Holder /			
Mother's Maiden Name:	Employment Authorization Document Holder?  ☐ Yes ☐ No			
	If yes, for how long?Years Months			
Applicant's work status:   Employed  Self-Employed  N/A  Most recent workplace name & phone number:/ ( )  Dates of most recent employment/self-employment:// to//				
Spouse's/domestic partner's work status: ☐ Employed ☐ Self-Employed ☐ N/A Most recent workplace name & phone number: / ( )				
Dates of most recent employment/self-employment:// to//				
Disability expected to last 12 months or longer?  ☐ Yes, mo. ☐ Yes, my spouse/domestic partner. ☐ No.				
☐ Yes, me ☐ Yes, my spouse/domestic partner ☐ No				

## **Household Status**

Please list all members of your family below, including yourself, your spouse or domestic partner, and dependent children under age 21 (whether living at home or not). Please also check the box  $(\Box)$  if you claim the person on your tax return.

Legal Name (Last, First, Middle)	Date of Birth (Month/Day/Year)	Relation to You	Social Security Number (if applicable)
(□)			
(□)			
(□)			
(□)			
(□)			
(□)			



#### **Healthcare Insurance and Access**

Do you have health insurance (including, but not limited to, Medicare, Medi-Cal, a Covered California plan, employer-sponsored coverage, and/or other third-party coverage for healthcare-related expenses)? ☐ Yes ☐ No		
Name(s) of insurance(s):		
Insurance contact number(s): ( )   ( )		
If you were injured, were your injuries caused by a third party (such as during a car accident or a slip and fall)? $\ \square$ Yes $\ \square$ No		
Do you have other insurance that may apply (like an auto policy)? ☐ Yes ☐ No		
Did you or your family pay any out-of-pocket healthcare expenses (such as copayments, coinsurance, deductibles, and bills not covered by insurance) in the past 12 months? ☐ Yes ☐ No		
If yes, please state the total amount paid: \$		
(If applicable) I have a primary care physician at: ☐ CSCHS ☐ a community clinic		
(If applicable) Name of primary care physician:		

## **Current Monthly Income**

Please fill out the below table using total gross income (i.e., before tax) numbers for all members of your family (including yourself, your spouse or domestic partner, and dependent children under age 21, whether living at home or not).

Monthly Income Source	Patient	Spouse	Other	DO NOT
1. Income from work (salary, wages, cash earnings, and other compensation)	\$	\$	\$	FILL OUT – FOR OFFICE
2. Income from operating a business (if self-employed)	\$	\$	\$	USE ONLY
3. Income from interest and dividends	\$	\$	\$	Total gross monthly
Income from real estate or personal property	\$	\$	\$	income:
5. Income from Social Security	\$	\$	\$	\$
6. Other income (specify:)	\$	\$	\$	Family Size:
7. Alimony / child support payments received	\$	\$	\$	- Faililly Size.
8. Alimony / child support payments PAID	\$	\$	\$	
Total income (add lines 1 through 7 above) minus any alimony / child support payments PAID (line 8)	\$			FPL Level:



# Important Notice Relating the Healthcare Access Program (HAP)

Program (HAP), you man Application to CSCHS we episode of care. If you explain why there is g	ust make all reasonable within 180 days of being submit your applicatingod cause for the del	scount under the CSCHS e efforts to submit your F g sent your first billing st on after this 180-day ti lay using the space be nation. CSCHS may also	Financial Assistance atement for a particular meframe, you must low. You may submit
Declaration and Si	gnature		
true and correct to the I answer to any question someone who did know System (CSCHS) of an eligibility for insurance point of service, which order to receive collaboration as well as to the determining Medi-Cal elemans were as the determining were as	best of my knowledge, or, I made every reasonally. I understand that I may change in my resider coverage within 60 day ever is earlier. I consend that I consenderative healthcare with procession of Santa Clara eligibility and sharing information.	rmation I have provided and that where I did not able attempt to confirm the ust inform the County of acy, financial status, hous of when the change of to release my health reproviders that contract we Social Services Agency formation about my Medirify any of the information	already know the answer with Santa Clara Health sehold size, and/or ccurs or at the next cord information in for purposes of i-Cal status. I authorize
 Date	 Signature		<del>-</del>