COUNTY OF SANTA CLARA
Health System

https://health.sccgov.org/retro-FA

经济援助申请表
适用于被催收 2018 年 10 月 28 日至 2021 年 12 月 31 日期间医院服务账单的患者

填写并通过以下方式交回此表格以及所需的证明文件：

- 邮寄或亲自送至：
  770 S. Bascom Avenue, San José, CA 95128
- 传真至：**1-408-494-7848**
- 通过电子邮件发送至：**FinancialAssistance@hhs.sccgov.org**

注：如果您选择通过电子邮件发送申请，我们建议您对邮件加密，以保护您个人文件的隐私和安全。

要获得资助资格，您必须填写此表格全部 3 页内容，并在随附通知（文件编号 22223）所示日期后 65 天内将其交还至相应县机构。随后，您需要在之后的 150 天内提交下一页指定的文件，以复核您的收入、身份和居住地。确切的截止日期请见通知。

在我们收到您填妥的表格和复核文件后，我们将决定您是否有资格享受全额或部分折扣，并以书面形式通知您。如果我们对您的申请有疑问，可能会打电话和/或写信给您。

您的名字（姓、名、中间名）	
出生日期（月/日/年）	
您的社会安全号码的后四位数	
电子邮件地址	☐ 选中此项表示您同意通过安全电子邮件接收与此申请相关的通信。
邮寄地址	
电话号码	
首选语言	

您是否对此表格有疑问或需要帮助？请联系圣克拉拉县卫生系统患者业务服务部（1-408-494-7850 或 1-888-524-3317 [TTY：711]，周一至周五上午 8:00 至下午 4:30）或健康消费者联盟 (1-888-804-3536) 获取免费帮助。

特殊情况 如果适用，请勾选右侧任一复选框。	☐ 被催收账户持有人现已去世。 ☐ 我在 2018 年 10 月 28 日至 2021 年 12 月 31 日期间的某个时间点是无固定居所者或无家可归者（请尽您所能指明具体日期）： _____
家庭状况 请考虑 2018 年 10 月 28 日至 2021 年 12 月 31 日期间您的全部家庭成员，并勾选相应复选框。 如果在此期间您的家庭成员的数量或状态发生了变化（例如，如果您与配偶离异或有子女年满 21 岁），请在空白处说明。	☐ 配偶或同居伴侣 ☐ 21 岁以下受抚养子女（无论是否住在家中） ☐ 子女人数：_____ 包括您在内的总人数： _____ ☐ 变化情况（如适用）： _____
被催收账单年份 请查看被催收账单年份。 如果您不确定您的被催收账单年份，请致电 1-408-494-7850 或 1-888-524-3317（TTY：711）（周一至周五上午 8:00 至下午 4:30）寻求帮助填写此表格，或选择“我不知道”。	☐ 2018 年 ☐ 2019 年 ☐ 2020 年 ☐ 2021 年 ☐ 我不知道

收入 请尽您所知提供被催收账单年份（您在上方选中的年份）中每一年的**家庭总收入**。 针对被催收账单的每个年份，您需要将您在上方列出的每位家庭成员（包括您在内）的收入累加。 **一定要计算**税前和扣除各项费用前的工资、业务经营收入、社保费用、失业补偿金、利息和股息收入，以及不动产或动产收入。 **不要计算**赡养费或子女抚养费。 如果您不确定您的被催收账单年份，请致电 1-408-494-7850 或 1-888-524-3317（TTY：711）（周一至周五上午 8:00 至下午 4:30）联系我们，我们会帮助您填写此表格，或为您提供所列每一年的家庭总收入。	这是我和我家人的： ☐ 年收入 ☐ 月收入 总额： 2018 年：_____美元 2019 年：_____美元 2020 年：_____美元 2021 年：_____美元
收入核实 证明被催收医院服务账单年份您的家庭总收入。	我同意针对每一适用年份，提供一份我和我的每位家庭成员的以下证明复印件（至少选择一项）： ☐ 纳税申报单 ☐ 工资单存根 ☐ 其他官方收入证明 ☐ 不确定，我仍在寻找证明
身份确认 证明您的身份（包括您的照片）。包括驾照、护照、政府颁发的其他身份证明，或者工作或学校身份证明。	我同意提供以下证件的副本（选择一项）： ☐ 驾照或护照 ☐ 政府颁发的其他身份证明 ☐ 其他带照片的身份证明： _____ ☐ 不确定，我仍在寻找证明
居住地证明 证明您在上方所勾选年份期间居住地所在县。 如果您不确定您的被催收账单年份，请提供 2018 年 10 月 28 日至 2021 年 12 月 31 日期间任何时间的居住证明。如果在此期间您所居住的县发生了变化，也请勾选右侧的框。	我将提供以下证明的复印件（选择一项）： ☐ 租赁合同/租约/抵押声明 ☐ 水电燃气费账单 ☐ 驾照或车辆备案 ☐ 其他：_____ ☐ 不确定，我仍在寻找证明 ☐ 我在 2018 年 10 月 28 日至 2021 年 12 月 31 日期间变更了居住县

我确认我提供的信息真实准确。

_____ _____

日期 签名

COUNTY OF SANTA CLARA
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FINANCIAL ASSISTANCE APPLICATION FOR PATIENTS WHOSE BILLS FOR HOSPITAL SERVICES WENT TO COLLECTIONS BETWEEN OCTOBER 28, 2018 AND DECEMBER 31, 2021

Complete and return this form along with the required verifying documents by:

- Mailing or personally delivering them to:
  770 S. Bascom Avenue, San José, CA 95128
- Faxing them to: **1-408-494-7848**
- E-mailing them to: **FinancialAssistance@hhs.sccgov.org**

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

To qualify for financial assistance, you must complete all 3 pages of this form and return them to the County within 65 days of the date on the accompanying notice (Document No. 22223). You will then have an additional 150 days to submit the documents specified on the following page to verify your income, identity, and residency. The exact due dates are in the notice.

After we receive your completed form and verifying documents, we will make a decision about whether you qualify for a full or partial discount and let you know in writing. We may call and/or write to you if we have questions about your application.

Your Name (Last, First, Middle)	
Date of Birth (month/day/year)	
Last Four Digits of Your Social Security Number	
E-mail Address	☐ Check here to consent to receive communications regarding this application by secure e-mail.
Mailing Address	
Phone Number	
Preferred Language	

Do you have questions or need help with this form? Call the County of Santa Clara Health System Patient Access Department at 1-408-494-7850 or 1-888-524-3317 (TTY: 711) (8am to 4:30pm, Monday to Friday) or the Health Consumer Alliance at 1-888-804-3536 for free assistance.

Special Circumstances Please check one of the boxes to the right if it applies.	☐ The person whose account was sent to collections is now deceased. ☐ I was transient or homeless at some point between October 28, 2018 and December 31, 2021 (specify dates, to the best of your recollection):
Household Status Check the box for each member in your family between October 28, 2018 and December 31, 2021. If the number or status of your family members changed during this time period (for example, if you and your spouse divorced or a child turned 21), please explain in the space provided.	☐ Spouse or domestic partner ☐ Dependent children under 21 years of age, whether living at home or not ☐ Number of children: _____ Total number of individuals, including you: _____ ☐ Changed circumstances (if applicable):
Year(s) Your Bill(s) Went to Collections Check the year(s) that your bill(s) went to collections. If you are not sure when your bill(s) went to collections, please call us at 1-408-494-7850 or 1-888-524-3317 (TTY: 711) (8am to 4:30pm, Monday to Friday) for help filling out this form or select "I do not know."	☐ 2018 ☐ 2019 ☐ 2020 ☐ 2021 ☐ I do not know

Income Provide, to the best of your knowledge, your **total gross family income** for each year you had bill(s) that went to collections (the year(s) you checked above). For each year you had bill(s) that went to collections, you need to add the income of each family member you listed above, including yourself. **Do count** pay from work before taxes and deductions, income from operating a business, Social Security payments, unemployment compensation, income from interest and dividends, and income from real estate or personal property. **Do not count** alimony or child support payments. If you are not sure when your bill(s) went to collections, please call us at 1-408-494-7850 or 1-888-524-3317 (TTY: 711) (8am to 4:30pm, Monday to Friday) for help filling out this form, or provide your total gross family income for every year listed.	This was my and my family's: ☐ annual (yearly) income ☐ monthly income Total amount: 2018: $_____ 2019: $_____ 2020: $_____ 2021: $_____
INCOME VERIFICATION This is proof of your total gross family income in the year(s) your bill(s) for hospital services went to collections.	I agree to provide, for each applicable year, a copy my and each of my family member's (choose at least one): ☐ Tax returns ☐ Pay stubs ☐ Other official income documentation ☐ Unsure, I am still searching for documents
IDENTITY VERIFICATION This is proof of your identity (including your photo). Examples include a driver's license, passport, other government-issued ID, or work or school ID.	I agree to provide a copy of my (choose one): ☐ Driver's license or passport ☐ Other government-issued ID ☐ Other photo ID: _____ ☐ Unsure, I am still searching for documents
RESIDENCY VERIFICATION This is proof of your county of residence for the year(s) you checked above. If you are unsure about when your bill(s) went to collections, please provide proof of residence for any time between October 28, 2018 and December 31, 2021. If your county of residence changed during this time, please also check the box to the right.	I will provide a copy of my (choose one): ☐ Rental contract/lease/mortgage statement ☐ Utility bill ☐ Driver's license or vehicle registration ☐ Other: _____ ☐ Unsure, I am still searching for documents ☐ My county of residence changed between October 28, 2018 and December 31, 2021

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

_____ _____

Date Signature