COUNTY OF SANTA CLARA
Health System

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

財務援助申請，適用於 2018 年 10 月 28 日至 2021 年 12 月 31 日間，其醫院服務帳單進入催收流程的患者

請填寫這份表格，並透過以下方式，連同必要驗證文件傳回此表格：

- 郵寄或親自送至：
  770 S. Bascom Avenue, San José, CA 95128
- 傳真至以下號碼：1-408-494-7848
- 透過電子郵件寄送至以下電子郵件信箱：
  FinancialAssistance@hhs.sccgov.org

註：如果您選擇透過電子郵件寄送您的申請，我們建議您將訊息加密，以保護個人文件的隱私與安全性。

若要符合取得財務援助的資格，您必須填寫這份表格的全部 3 個頁面，並在隨附通知 (文件編號：22223）上列日期起 65 天內將其傳回至本郡。隨後您將另有 150 天可提交下頁指定的文件，以便驗證您的收入、身分與居住地。準確的截止日期列於通知中。

在我們收到您已填妥的表格以及驗證文件後，我們會決定您是否符合全額折扣或部分折扣的資格，並以書面形式向您告知此決定。如果我們對您的申請有任何問題，我們將會撥打電話和/或寄送信件給您。

您的姓名（姓氏、名字、中間名）	
出生日期（月/日/年）	
您的社會安全號碼末四碼	
電子郵件地址	☐ 請勾選此處，以同意透過安全電子郵件收到此申請的相關通訊。
郵寄地址	
電話號碼	
慣用語言	

您是否對這份表格有任何問題或是需要協助？ 請致電聖塔克拉拉衛生系統風險分攤部門 (County of Santa Clara Health System Patient Access Department)，電話號碼是 1-408-494-7850 或 1-888-524-3317（聽障者服務專線 (TTY)：711）（週一至週五，上午 8 點至下午 4 點 30 分），或致電健康消費者聯盟 (Health Consumer Alliance)，電話號碼是 1-888-804-3536，以取得免費協助。

特殊情況 如果右側項目適用於您，請勾選其中一個方塊。	☐ 其帳戶進入催收流程的人員現已過世。 ☐ 在 2018 年 10 月 28 日至 2021 年 12 月 31 日間，我曾為短暫居住者或街友（請指定日期，以印象中最明確的日期為準）：
家庭狀態 請勾選 2018 年 10 月 28 日至 2021 年 12 月 31 日間您家中每位成員的方塊。 如果在這段時間，您的家庭成員人數或狀態改變（例如，如果您與配偶離婚，或子女年滿 21 歲），請在提供的空格中提供說明。	☐ 配偶或同居伴侶 ☐ 受撫養子女的年齡未滿 21 歲（無論是否居住在家中） ☐ 子女人數：_____ 總人數（包含您在內）： _____ ☐ 變化狀況（如適用）：
您的帳單進入催收流程的年度 請勾選您的帳單進入催收流程的年度。 如果您不確定您的帳單進入催收流程的時間，請致電我們，電話號碼是 1-408-494-7850 或 1-888-524-3317（聽障者服務專線 (TTY)：711）（週一至週五，上午 8 點至下午 4 點 30 分），我們將協助您填寫這份表格，或請選擇「不知道」。	☐ 2018 ☐ 2019 ☐ 2020 ☐ 2021 ☐ 不知道

收入 請根據您的瞭解，提供每一個您的帳單進入催收流程的年度（您在上方勾選的年度）中，您的**家庭總收入**。 針對每一個您的帳單進入催收流程的年度，您必須加入您在上方列出之成員的收入，包含您自己在內。 **請確實計入**稅前與扣除前的工作薪資、來自經營企業的收入、社會安全給付、失業補償金、利息收入和股利與來自於房地產或個人不動產的收入。 **請勿計入**贍養費或子女撫養費。 如果您不確定您的帳單進入催收流程的時間，請致電我們，電話號碼是 1-408-494-7850 或 1-888-524-3317（聽障者服務專線 (TTY)：711）（週一至週五，上午 8 點至下午 4 點 30 分），或提供每一個您列出年度的家庭總收入。	這是我和我的家人的： ☐ 年度（每年）收度 ☐ 每月收入 總金額： 2018 年：$_____ 2019 年：$_____ 2020 年：$_____ 2021 年：$_____
收入驗證 這是在您的醫院服務帳單進入催收流程的年度，您的家庭總收入證明。	我同意針對以下文件，提供我和我的家庭成員在每個適用年度的文件副本（至少選擇一項）： ☐ 納稅申報單 ☐ 薪資單 ☐ 其他正式收入文件 ☐ 不確定，我仍在搜尋文件
身分驗證 這是您的身分證明（包含您的照片）。範例包含駕照、護照、其他由政府核發的身分證，或工作證件或學生證。	我同意提供以下證件的副本（選擇一項）： ☐ 駕照或護照 ☐ 其他由政府核發的身分證 ☐ 其他照片證件：_____ ☐ 不確定，我仍在搜尋文件
居住地驗證 這是您在上方勾選的年度中，您的居住郡證明。 如果您不確定您的帳單進入催收流程的時間，請提供在 2018 年 10 月 28 日至 2021 年 12 月 31 日間任何時間點的居住地證明。如果您在這段時間變更您的居住郡，請您同樣勾選右側的方塊。	我將提供以下文件的副本（選擇一項）： ☐ 租約/租賃/抵押貸款聲明 ☐ 公用事業帳單 ☐ 駕照或車輛登記 ☐ 其它：_____ ☐ 不確定，我仍在搜尋文件 ☐ 我在 2018 年 10 月 28 日至 2021 年 12 月 31 日間變更了我的居住郡

我確認我提供的資訊正確無誤。

_____ _____

日期 簽名

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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