UCSF Medical Center

UCSF Benioff Children's Hospitals

**UCSF MEDICAL CENTER**
**Financial Assistance Application**

| *1. PATIENT INFORMATION* | | | | |
|---|---|---|---|---|
| **Last Name** | **First Name** | **Initial** | **Account Number** | **Med. Record No.** |
| | | | | |

| *2. APPLICANT INFORMATION* | **RELATIONSHIP TO PATIENT** ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** _____ | **Marital Status** ☐ Married ☐ Single ☐ Separated **IF MARRIED, SECTION 3 MUST BE COMPLETED** | |
|---|---|---|---|
| **Last Name** | **First Name** | | **U.S. Citizen (see #6)** ☐ Yes ☐ No |
| **Date of Birth** | **No. of Dependents** (under age 21, other than self & spouse) | **Ages of Dependents** | **Home Phone** ( ) |

| **Street Address** (Do Not List PO Box) | **City** | **State** | **County** | **Zip** |
|---|---|---|---|---|
| | | | | |

| **Current Employer** | **Street Address, City, State** | **Position** |
|---|---|---|
| | | |

| *3. CO-APPLICANT INFORMATION* | | | **RELATIONSHIP TO PATIENT** ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** _____ |
|---|---|---|---|
| **Last Name** | **First Name** | **Initial** | **Relationship to Applicant** | **U.S. Citizen (see #6)** ☐ Yes ☐ No |
| | | | | |

| **Date of Birth** | **No. of Dependents** (do not include those claimed by applicant) | **Ages of Dependents** | **Home Phone** ( ) |
|---|---|---|---|
| | | | |

| **Street Address** ( Do Not List PO Box) | **City** | **State** | **County** | **Zip** |
|---|---|---|---|---|
| | | | | |

| **Current Employer** | **Street Address, City, State** | **Position** |
|---|---|---|
| | | |

| ***4. INCOME INFORMATION*** **(Supporting documentation required. To list additional income, use back of this application)** | | | | **Combined Monthly Income** |
|---|---|---|---|---|
| | **Monthly Income Sources** | **Applicant** | **Co-Applicant** | |
| | Employment Income | $ | $ | $ |
| | Social Security | $ | $ | $ |
| | Alimony/Child Support | $ | $ | $ |
| | Other: (*Unemployment, Disability, Pension, etc*.) | $ | $ | $ |
| | | **Total Combined Monthly Income** | | $ |

| ***5. ASSETS*** **(To list additional assets, use back of this application)** | | | |
|---|---|---|---|
| **Checking/Money Market/Savings Accounts:** | | | |
| **Bank Name:** | **Branch/Address** | | **Monthly Balance/ Value** |
| 1. | | | $ |
| 2. | | | $ |
| **Other Cash Assets:** | | | $ |
| | | **Total Asset Value** | $ |
| | | | |
| | | | |

## *6. SUPPORTING DOCUMENTATION (REQUIRED)*

Application will be returned if supporting documentation is missing. Acceptable proof of income includes:
***(Bank statements will not be accepted as proof of income)***

**From both applicant & co-applicant**

- ✓ Copy of most recent (2 months) pay stubs for **both** applicant & co-applicant.
- ✓ Copy of current year or previous year's W-2 or 1099 earnings statements for **both** applicant & co-applicant.
- ✓ Copy of **signed** current year's or previous year's Income Tax Return
- ✓ Copy of Social Security Allotment letter and/or other proof of income **(section 4)**
- ✓ Copy of valid Legal Permanent Resident card if non-US citizen is required.

## *7. COMMENTS*

Enter any additional information relevant to your request not reflected on this application.

***8. SIGNATURE AND DATE (REQUIRED OF APPLICANT AND CO-APPLICANT)***

I certify that all information is true and complete, and hereby authorize UCSF Medical Center to request a credit check report and/or verify any of the above information as deemed necessary. I understand that incomplete applications will be returned to the applicant. I understand that I may be required to complete a new application for future services. I agree to notify UCSF Medical Center of any changes to my financial circumstances that may affect my eligibility for financial assistance.

| **Applicant** | **Date** | **Co-Applicant** | **Date** |
|---|---|---|---|
| _____ | | _____ | |