STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center

Financial Assistance Application

Stanford Hospital & Clinics have a variety of options available for uninsured or underinsured patients. Our financial assistance options include:

No Application Necessary

- **Uninsured Discounts-** *Some services may be excluded.*
- **No Interest Payment Plans –** *Balances to be paid generally within 6 months.*

Application Required

- **Financial Need Discounts-** *Discount at a rate comparable to our government payers. Some services may be excluded.*
- **Full Financial Assistance-** *100% of patient portion due. Some services may be excluded.*
- **Extended No Interest Payment Plans-** *Available to patients who qualify for financial need discounts.*

A completed financial assistance application and proof of income must be submitted in order for us to consider a financial need discount and/or full financial assistance. Once we receive your completed application we may assess whether or not you qualify for state or county programs. If this assessment determines you do not qualify for these programs we will evaluate your financial assistance application to determine if you qualify for a financial need discount or full financial assistance. Those who qualify may receive assistance with their hospital bills for services provided at Stanford Hospital and physician bills for physicians employed by Stanford University.

Financial need discounting and full financial assistance is not available for all services. Consideration for future services will be based on medical necessity and catastrophic costs.

In considering financial assistance, our first priority is to assist those who have had emergency services. Next, is to assist those who have had or will have medically necessary non-emergency services falling within either of the following two categories:

A. Category 1: Stanford Hospital & Clinics is the closest hospital to the patient's home or place of work; or

B. Category 2: Stanford Hospital & Clinics is not the closest hospital to the patient's home or place of work but one or more of the following factors apply:

   (a) The patient has a unique or unusual condition which requires treatment at Stanford Hospital & Clinics as determined by the Chief Quality and Medical Information Officer of SHC.

   (b) The patient's care would further the institutions teaching mission as determined by the Chief Quality and Chief Medical Officer of SHC.

SHC FINANCIAL ASSISTANCE APPLICATION
Customer Service: (800) 794-8978 Fax: (650) 493-8623

Important Information Required With Application

Failure to provide the following required information or an explanation as to why this information is not available may delay the processing of your application and could result in a denial for assistance:

- **Proof of Income**: Provide copies of the last two pay stubs or the last tax return for both applicant and co-applicant.
- Indicate if the patient is applying for a financial need discount or full financial assistance.
- Indicate if the patient is applying for financial assistance to cover past and/or future services.
- List the patient as applicant, and if appropriate, the spouse/domestic partner as co-applicant. If the patient is under the age of 18, list the parent(s) or custodian as applicant and co-applicant if applicable.
- If the patient has applied for Medi-Cal or other government program, provide the status of the application or a copy of the denial.
- If the patient has medical coverage, provide the information as listed on the member's identification card.
- If the patient's services are a result of an injury covered by Workers Compensation, Third Party Liability (such as an auto accident) or Victims of Crime, provide the specific information requested on the application.

Every reasonable effort will be made to process your application promptly and once your application has been reviewed you will receive a letter confirming the outcome. Completed applications may be mailed with the supporting documentation to the address listed below:

Stanford Hospital and Clinics
Attention: Patient Financial Assistance
2465 Faber Place
Palo Alto, Ca. 94303

Applications may also be faxed to (650) 493-8623.

Thank you for choosing Stanford Hospital & Clinics for your care.

STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center

FINANCIAL ASSISTANCE APPLICATION

DATE OF APPLICATION: _____

*1. PATIENT INFORMATION** *- PLEASE PRINT ALL INFORMATION-*			
Last Name	**First Name**	**Middle Initial**	**Medical Record Number**

***If the patient is a minor, please list parent(s)/guardian(s) as applicant and co-applicant.**

2. APPLICANT (GUARANTOR) INFORMATION			**RELATIONSHIP TO PATIENT** ☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other _____ **MARITAL STATUS** ☐ Single ☐ Married/Domestic Partner ☐ Divorced ☐ Separated	
Last Name	**First Name**	**Middle Initial**	**U.S. Citizen** ☐ Yes ☐ No	
Date of Birth	**No. of Dependents** (other than self& co-applicant)	**Ages of Dependents**	**Home Phone** ( )	
Street Address (Do Not List PO Box)		**City** / **State**	**County**	**Zip**
Current Employer		**Street Address, City, State**	**Position**	
*** If you are not working, how long have you been unemployed?**				

3. CO-APPLICANT (GUARANTOR) INFORMATION			**RELATIONSHIP TO PATIENT** ☐ Spouse/Domestic Partner ☐ Parent ☐ Other _____	
Last Name	**First Name**	**Middle Initial**	**U.S. Citizen** ☐ Yes ☐ No	
Date of Birth	**No. of Dependents** (don't include those claimed by co-applicant)	**Ages of Dependents**	**Home Phone** ( )	
Street Address (Do Not List PO Box)		**City** / **State**	**County**	**Zip**
Current Employer		**Street Address, City, State**	**Position**	
*** If you are not working, how long have you been unemployed?**				

PFS-Patient Financial Assistance
Edits: 10/20/13, 07/02/12, 01/01/07, 11/17/04; 11/04/04; 6/12/02

***4. FINANCIAL ASSISTANCE QUESTIONS*: -- (All answers pertain to the patient)**		
		Check appropriate answer
1.	Is the patient applying for assistance with bills for past services at Stanford Hospital & Clinics? If yes, please indicate the last service date:_____	☐ Yes ☐ No
2.	Is the patient applying for assistance with bills for current and/or future services at Stanford Hospital & Clinics? If yes, please indicate/describe the types of services anticipated:_____ _____ _____	☐ Yes ☐ No
3.	Is the patient applying for a discount off their bills from Stanford Hospital & Clinics ?	☐ Yes ☐ No
4.	Is the patient applying for 100% assistance with their bills for services provided at Stanford Hospital & Clinics?	☐ Yes ☐ No
6.	Does the patient have health insurance? If yes, please provide the following information: Health Insurance Name:_____ Subscribers Name:_____ Members/Patients Identification Number:_____Group Number:_____ Group/Employer Name:_____ Effective Date:_____ Health Insurance Telephone Number:_____	☐ Yes ☐ No
7.	Is the patient eligible for a state medical assistance program? If yes, please provide the following information: Name of program:_____ County:_____ Patient Identification Number:_____	☐ Yes ☐ No
8.	Is the patient being treated for injuries covered by Workers Compensation? If yes, please provide the following information: Name of Work Comp Carrier:_____ Adjusters Name:_____ Adjusters Phone Number:_____ Injury Date:_____ Claim/Case Number:_____	☐ Yes ☐ No
9.	Is the patient being treated for injuries covered by Third Party Liability such as an Auto Insurance Company? If yes, please provide the following information: Name of Auto insurance or Attorney:_____ Auto Insurance or Attorney Phone Number:_____ Injury Date:_____ Claim/Case Number:_____	☐ Yes ☐ No
10.	Is the patient a Victim of Crime? If yes, please provide the following information: Date of injury? _____ Name of Case Worker:_____ Case Workers Phone Number:_____ Case Number:_____	☐ Yes ☐ No

5. INCOME INFORMATION **(To document additional income use Page 4 of this application)**			
Monthly Income Sources	**Applicant**	**Co-Applicant**	**Combined Monthly Income**
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other[s] use these spaces	$	$	$
	$	$	$
	$	$	$
	$	$	$
Total Combined Monthly Income			$

UNEMPLOYMENT: If you do not have monthly income, please explain how you take care of your monthly expenses:

6. ASSETS **(To document additional assets use Page 4 of this application)**			
Checking/Money Market/Savings Accounts:		******List all available funds.**	
Name:	**Current Balance**	**Bank Name:**	**Current Balance**
1.	$	4.	$
2.	$	5.	$
3.	$	6.	$

7. INCOME AND FAMILY SIZE TABLE

STOP!

Compare your monthly household income and family size to the table below.

1) **If your monthly household income is below the amount shown for your family size, do not complete Section 8 (Estimated Monthly Living Expenses). Please continue and complete Section 9 and Section 10.**

2) **If your monthly household income is above the amount shown for your family size, you must complete section 8, 9 and 10.**

Family Size	*Monthly Household Income*		*Family Size*	*Monthly Household Income*
1	**$ 3,830.00**		**5**	**$ 9,190.00**
2	**$ 5,170.00**		**6**	**$ 10,530.00**
3	**$ 6,510.00**		**7**	**$ 11,870.00**
4	**$ 7,850.00**		**8**	**$ 13,210.00**

8. ESTIMATED MONTHLY LIVING EXPENSES **(To document additional monthly living expenses use Section 9)**

Monthly Expenses	**Monthly Payment**	**Monthly Expenses**	**Monthly Payment**
House/Mortgage Payment	$	Current Outstanding Bills for Medical, Dental, or Prescriptions	$
Property Taxes (if not included in mortgage payment)	$	Total Monthly Automobile Payment(s)	$
Home Owner's Insurance (if not included in mortgage payment)	$	Automobile Insurance	$
Utilities (Electricity, Gas, Water, Garbage, Recycling, etc.)	$	Automobile Gasoline	$
Food	$	Liens/ Wage Garnishments	$
Telephone (home line and/or cell)	$	List Other Monthly Payments	$
Child Support	$		$
Spousal Support/Alimony	$		$
Child Care	$		$
Credit Cards	$		$
Health Insurance Premiums	$	***Total Monthly Payments***	$

9. ADDITIONAL INFORMATION & COMMENTS:

ADDITIONAL COMMENTS – IF YOU NEED MORE SPACE, PLEASE USE THE BACK OF THIS PAGE

10. SIGNATURE

I certify that all information is valid and complete and hereby authorize Stanford Hospital & Clinics to request a credit check report and/or verify any of the above information as deemed necessary.

Applicant **Date** **Co-Applicant** **Date**

Return completed application to:	**SHC Patient Financial Assistance** **Patient Financial Services** **2465 Faber Place** **Palo Alto, CA 94303**