Financial Assistance Application

Stanford Health Care 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 Health Care is the closest hospital to the patient's home or place of work; or

B. Category 2: Stanford Health Care 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 Health Care 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.

Important Information Required With Application

Proof of Income (POI): Kindly provide the following information or an explanation as to why this information is not available. Missing documentation may delay the processing of your application and could result in a denial for assistance.

Below is a listing of the POI documentation that is required for consideration of SHC Financial Assistance.	
Type of Income	**Required documentation**
Employment Income	• Copy of Individual tax return (Form 1040) for current tax year • Copy of two most recent paystubs
Self-Employment	• Copy of Individual tax return (Form 1040) for current tax year
Social Security/Retirement	• Copy of Individual tax return (Form 1040) for current tax year • Copy of Award Letter from Social Security Administration stating monthly payment • Copy of monthly payment notification from Social Security Administration
Disability	• Copy of Individual tax return (Form 1040) for current tax year • Copy of Award Letter from disability stating monthly disability payment • Copy of monthly payment notification from disability
Unemployment	• Copy of Individual tax return (Form 1040) for current tax year • Copy of Award Letter from unemployment stating weekly or monthly benefit amount • Copy of monthly payment notification from unemployment
Spousal/Child Support	• Copy of Individual tax return (Form 1040) for current tax year • Copy of letter stating monthly award amount
Rental Property	• Copy of Individual tax return (Form 1040) for current tax year
Investment Income	• Copy of Individual tax return (Form 1040) for current tax year
Proof of Dependents	• Copy of Individual tax return (Form 1040) for current tax year
Proof of Enrollment (Student)	• Copy of current quarter/semester college or university registration/enrollment letter or report card

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 required supporting documentation to the address listed below:

Stanford Hospital and Clinics
Attention: Patient Financial Assistance
P.O. BOX 740715
Los Angeles, CA 90074-0715

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

Stanford HEALTH CARE
STANFORD MEDICINE

FINANCIAL ASSISTANCE APPLICATION

DATE OF APPLICATION: _____

1. FAMILY INFORMATION (PLEASE PROVIDE NAMES OF ALL PEOPLE TO BE CONSIDERED FOR FINANCIAL ASSISTANCE) - PLEASE PRINT ALL INFORMATION-			
Last Name	**First Name**	**Middle Initial**	**Medical Record Number**
Last Name	**First Name**	**Middle Initial**	**Medical Record Number**
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 ☐ Widow

IF YOU MARKED YES TO MARRIED OR DOMESTIC PARTNER: PLEASE COMPLETE SECTION 3

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?**

4. OTHER COVERAGE QUESTIONS: -- **(All answers pertain to the patient)**		
		Check appropriate answer
1.	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
2.	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
3.	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
4.	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
5.	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			
Monthly Income Sources	**Applicant**	**Co-Applicant**	**Combined Monthly Income (Applicant + Co-Applicant)**
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other[s] use these spaces	$	$	$
	$	$	$
		Total Combined Monthly Income	$

6. IF YOU DO NOT HAVE MONTHLY INCOME, PLEASE EXPLAIN HOW YOU TAKE CARE OF YOUR MONTHLY EXPENSES. USE ADDITIONAL PAGES IF NECESSARY

7. SIGNATURE

I certify that all information is valid and complete and hereby authorize Stanford Health Care to request 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** **P.O. BOX 740715** **Los Angeles, CA 90074-0715**