Stanford HEALTH CARE

UNIVERSITY HEALTHCARE ALLIANCE
FINANCIAL ASSISTANCE APPLICATION

University HealthCare Alliance ("UHA") has a variety of options available to the uninsured, or underinsured, patient. These include uninsured discounts and no-interest payment plans that do not require completion of this application. Discuss these options with the UHA Financial Counselor.

Completion of Financial Assistance Application Form is Required to Establish:

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

A completed form and proof of income must be submitted in order for us to consider a financial need discount and/or financial assistance. Once we receive the completed application, we may assess whether or not you qualify for state or county programs. If you do not qualify for any of these programs, we will determine if you quality for financial need discount or full financial assistance. Those who qualify may receive assistance with their physician bills for physicians employed by University HealthCare Alliance.

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.

Proof of income includes:

1. Copy of last two pay stubs and most current bank statement
2. Copy of last tax return (for both applicant and co-applicant, if appropriate)

Submit completed form to:

University Healthcare Alliance
PO Box 3062
Hayward, CA 94540-9700

University HealthCare Alliance ("UHA") is a medical foundation affiliated with Stanford Health Care and Stanford Medicine. UHA contracts with a number of physician groups to provide the medical care in the UHA clinics. Neither UHA, Stanford Health Care, nor Stanford University employ the physicians in the clinics and do not exercise control over the professional services provided by the physician groups.

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FINANCIAL ASSISTANCE APPLICATION

Date of Application:_____

SECTION 1 – PATIENT INFORMATION					
Last Name:	**First Name:**	**MI**	**Medical Record Number**		

SECTION 2 – APPLICANT (GUARANTOR) INFORMATION					
Relationship to Patient: Self__ Spouse/Domestic Partner__ Parent__ Other__, specify:_____					
Marital Status: Single__ Married/Domestic Partner__ Divorced__ Separated__					
Last Name:	**First Name:**	**MI**	**Social Security #**	**US Citizen Yes__ No__**	
Date of Birth	**# of Dependents**	**Ages of Dependents:**	**Primary Phone ( )**		
Street Address:		**City**	**State**	**County**	**Zip**
Current Employer	**Street Address, City, State**		**Position**		
If you are not working, how long have you been unemployed?					

SECTION 3 – CO-APPLICANT (GUARANTOR) INFORMATION					
Relationship to Patient: Spouse/Domestic Partner__ Parent__ Other__, specify:_____					
Last Name:	**First Name:**	**MI**	**Social Security #**	**US Citizen Yes__ No__**	
Date of Birth	**# of Dependents**	**Ages of Dependents:**	**Primary Phone ( )**		
Street Address:		**City**	**State**	**County**	**Zip**
Current Employer	**Street Address, City, State**		**Position**		
If you are not working, how long have you been unemployed?					

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SECTION 4 – FINANCIAL ASSISTANCE QUESTIONS (answer all that apply to patient)		
1	Is the patient applying for assistance for past services? If yes, please indicate last service date:_____	Yes __ No__
2	Is the patient applying for assistance for current/future service? If yes, describe types of services:_____	Yes __ No__
3	Is the patient applying for discount off their bills?	Yes __ No__
4	Is the patient applying for 100% assistance with their bills?	Yes __ No__
5	Does the patient have health insurance? If yes, health insurance name_____ subscriber:_____ policy #_____	Yes __ No__
	Is the patient eligible for a state medical assistance program? Name of Program_____ County_____ Patient ID#_____	Yes __ No__
7	Is the patient being treated for injuries covered by Workers Compensation? Claim/Case #_____ Adjusters name_____ Adjusters phone#_____	Yes __ No__
8	Is the patient being treated for injuries covered by Third Party Liability, such as an Auto Insurance Company? Name of Insurance_____ Claim/Case Number_____ Contact Person_____ Contact Phone #_____	Yes __ No__

SECTION 5 – INCOME INFORMATION (attach additional pages, as necessary)			
Monthly Gross Income Source	Applicant	Co-Applicant	Combined Monthly Income
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other, specify_____	$	$	$
Other, specify_____	$	$	$
Other, specify_____	$	$	$
Total combined Monthly Income			

SECTION 6 – ASSETS (checking, savings, money markets, etc				
Institution Name:	Current Balance		Institution Name:	Current Balance

SECTION 7 – INCOME AND FAMILY SIZE TABLE					
Compare your monthly household income and family size to the table below. If your total is **below** the amount shown for your family size, **do not complete section 8**					
Family Size	Monthly Household Income		Family Size	Monthly Family Income	
1	$ 3,923.33		5	9,470.00	
2	$ 5,310.00		6	$ 10,856.67	
3	$ 6,696.67		7	$ 12,010.00	
4	$ 8,083.33		8	$13,630.00	

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SECTION 8 – ESTIMATED MONTHLY LIVING EXPENSES (attach additional pages, as necessary)			
House Mortgage/Rent	$	Health Insurance	$
Property Taxes (not in mortgage)	$	Credit Cards	$
Home Owners Insurance	$	Auto Insurance	$
Auto Payments	$	Outstanding medical bills	$
Utilities	$	List other monthly payments	
Food	$		$
Telephone	$		$
Gasoline	$		$
Child Support	$		$
Alimony	$		$
Child Care	$		$
		Total Monthly Payments	

SECTION 9 – ADDITIONAL INFORMATION AND COMMENTS

SECTION 10 - SIGNATURE

I certify that all information is valid and complete and hereby authorize University HealthCare Alliance to request a credit check report and/or verify any information deemed necessary.

_____ _____

Applicant Signature Date

_____ _____

Co-Applicant Signature Date

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University HealthCare Alliance
Financial Assistance Certification

Patient Name: _____

MRN: _____

I _____ (Guarantor/Responsible Party) am requesting a discount on my billed charges. I estimate in good faith my annual gross family income to be $_____. I am uninsured and/or underinsured without coverage for certain ***medically necessary services*** provided by University HealthCare Alliance.

I understand that I may apply for financial assistance if I wish to pursue a discount greater than the Uninsured Patient Discount offered to me today.

_____ _____
Signature of patient/guarantor Date
(if other than patient, include relationship)

Please include the following documents:

- Documentation of Family Income – Recent Pay Stubs or Income Tax Return
- Health Benefit Coverage

UHA Staff Use Only
For use when discount is requested over the phone.

Representative Name: _____
Representative Signature: _____

Department: _____

___ Above Statement Certified Verbally by Patient on _____
(Date and Time)
___ Informed Patient of Financial Options including Financial Assistance Program

Notes/Comments:_____