

FINANCIAL ASSISTANCE PROGRAM FOR LOW INCOME UNINSURED PATIENTS FREQUENTLY ASKED QUESTIONS

How Do I Determine Whether I Qualify For Financial Assistance For My Hospital Medical Bills?

CPMC offers Financial Assistance to our low-income, uninsured patients that meet the program eligibility requirements. Please refer to the chart, located on the back of this notice, for the family income eligibility criteria.

If your family income is below 400% of the Federal Poverty Income Guidelines you may qualify for 100% Charity Care for your hospital bill.

Catastrophic medical coverage is also available for uninsured patients whose eligible medical bills exceed 15% of the patient's annual family income.

The Patient Financial Services department will begin the eligibility determination process once they have received a completed application form along with your income verification documents. **Failure to submit a completed application and supporting documentation in a timely manner may result in denial of charity care.**

How Do I Apply For Financial Assistance?

Complete the attached form and return to the **CPMC Patient Financial Services** office at the following address:

**PO Box 7999
San Francisco, CA 94120
Fax: 415-600-7105**

You must provide income documentation, such as tax return, pay stubs, or employer salary history, with your application to process your charity request.

The Patient Financial Services office will process your application and may need to contact you as part of the application process and may request additional information. If you need assistance in completing the form please call 415-600-7280.

How Does The Notification Process Work?

Once the eligibility process is complete you will receive a Financial Assistance Notification form in the mail. The form will indicate if you are eligible for Financial Assistance. You may receive a notification that you are ineligible for financial assistance or that more information is needed to make a determination.



STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____
ADDRESS _____
ACCOUNT# _____

SPOUSE _____
PHONE _____
SSN# _____
(Patient) (Spouse)

FAMILY STATUS: List all dependents that you support

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT AND OCCUPATION

Employer _____ Position _____
Contact Person & Telephone _____
If Self-Employed, Name of Business _____

Spouse Employer _____ Position _____
Contact Person & Telephone _____
If Self-Employed, Name of Business _____

CURRENT MONTHLY INCOME

	Patient	Spouse
Wages or Income from Operating Business (if Self-Employed)	_____	_____
<i>Add:</i> Other Income:		
Interest and Dividends	_____	_____
From Real Estate or Personal Property	_____	_____
Social Security	_____	_____
Other (specify):	_____	_____
Alimony or Support Payments Received	_____	_____
<i>Subtract:</i> Alimony, Support Payments Paid	_____	_____
<i>Equals:</i> Current Monthly Income	_____	_____
Total Current Monthly Income	_____	_____
(add Patient + Spouse income from above)	_____	_____



California Pacific
Medical Center

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FAMILY SIZE

Total Family Members (add patient, spouse and dependents from above) _____

By signing this form, I agree to allow Sutter Health to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I may be required to provide proof of the information I am providing.

(Signature of Patient or Guarantor)

(Date)

(Signature of Spouse)

(Date)