SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Department of Public Health
San Francisco General Hospital and Trauma Center
Laguna Honda Hospital and Rehabilitation Center
Primary Care Network

CHARITY CARE AND DISCOUNT PAYMENT PROGRAMS

APPLICATION

APPLICANTS MUST MEET THE FOLLOWING CRITERIA TO BE CONSIDERED FOR ELIGIBILITY TO THE CHARITY CARE OR DISCOUNT PAYMENT PROGRAMS:

- Must not be eligible for government / non-government payers
- Must not have any third party liability
- May have high medical expenses/costs
- Must apply for services received at San Francisco General Hospital or Community Primary Care Clinic
- Must apply for services that have not already been discounted
- Must have a gross family household income at or below 350% federal poverty level
- Must provide most recent quarter's pay stubs or most recent year tax return statement
- Must provide verification of qualified liquid assets for Charity Care consideration
- Must provide verification of high paid medical expenses in the past 12 months or have high SFGH or Community Primary Care Clinic medical expenses for Discount Payment consideration

INSTRUCTIONS FOR APPLYING:

- Complete and sign this application
- Submit your application and verification documents by:
    - Mail your application and verification documents or drop in to apply at:

San Francisco General Hospital Billing Office
Building 20, 4th Floor, Room 2406
San Francisco, CA 94110

- Call (415) 206-3275 for detailed information

APPLICANT INFORMATION

Last name:	First name:
Date of Birth:	Medical Record #:

PERMANENT ADDRESS

Address:	City:
State:	Zip Code:
Country:	Telephone:
Cell Phone:	Email:

TEMPORARY ADDRESS (if applicable)

Address:	City:
State:	Zip Code:
Country:	Telephone:
Cell Phone:	Email:

ELIGIBILITY & SCREENING

What is your marital status?	☐Married ☐Single ☐Widowed ☐Separated ☐Divorced ☐Domestic Partner
Do you have a medical insurance?	☐Yes ☐No ***If yes, specify:*** ***Provide Insurance card.***
Do you have a disability expected to last 12 months?	☐Yes ☐No
Do you have a pending application with Medi-Cal?	☐Yes ☐No
Were you pregnant on the date of service?	☐Yes ☐No N/A
Family Size (self, spouse and children under 21 yrs old)	# _____
Total family gross monthly income at the time of application:	$ _____ ***Provide most recent quarter (3 mos.) pay stubs or most recent year tax return.***
Total assets at the time of application *(**excluding** retirement and deferred compensation plans:*	$ _____ ***Provide financial statements most recent quarter (3 mos.) to date of application.***
Identify all types of asset accounts held:	☐Checking ☐Savings ☐Money Market ☐Certificate of Deposit ☐Brokerage ☐Mutual Fund ***Provide statements for all accounts held.***
Do your SFGH medical expenses exceed 110% of your family annual income?	☐Yes ☐No
Have your paid medical costs in the past 12 months exceeded 110% of your family annual income?	☐Yes ☐No ***Provide receipts verifying paid amounts.***

I declare the answers given are true and correct to the best of my knowledge. I am uninsured or underinsured and have no third party liability. I understand that the information I have provided will be verified. I understand that the information will be used to screen for eligibility to various Federal, State and County Programs. I understand that if my information is found to be false, I will be held responsible for the full amount of any fee for medical services received from San Francisco General Hospital or the Community Primary Care Clinics.

APPLICANT SIGNATURE:	*DATE:*

PENDING DOCUMENTS – 30 DAY TIME-LIMIT TO SUBMIT

☐ 3 Months of Pay Stubs or Recent Tax Returns ☐ 3 Months of all bank statements

Comments:

ELIGIBILITY DEPARTMENT DETERMINATION

FPL	Outpatient Charity	Outpatient Discount	Inpatient Charity	Inpatient Discount
0-133%	**IPC 822**	**IPC 829**	**IPC 822**	**IPC 841**
134-200%	**IPC 823**	**IPC 829**	**IPC 843**	**IPC 841**
201-350%	**IPC 824**	**IPC 829**	**IPC 844**	**IPC 841**

Charity Program ☐Eligible ☐Ineligible

Discount Program ☐Eligible ☐Ineligible

Denial Reasons:

☐Non-compliance ☐Income over 350% FPL

☐Insured by government or non-government payer ☐No high medical costs

☐Services were not received at SFGH ☐Services received are already discounted

☐**Over 30 Days – Failed to provide requested verifications**

☐Other (specify) _____

Eligibility determination made by:

Print Name:

Signature: Date:

Date sent to patient for final determination: Financial Counselor Initials:

cc: Copy sent to patient

If you have been determined ineligible for the Charity Care and Discount Payment programs and wish to appeal your denial for eligibility, you have **15 business days** to appeal from the date of your eligibility determination. Please submit a copy of this completed application with your written statement below of the reason for your appeal request to:

San Francisco General Hospital • 1001 Potrero Avenue, Ward 15 • San Francisco, CA 94110
Attention: Jenine Smith, Eligibility Manager

Reason for Appeal • Appeals Decision

Reason for appeal request:

APPEALS DECISION

Charity Program	☐Eligible	☐Ineligible
Discount Program	☐Eligible	☐Ineligible

Decision made by:

Print Name:

Signature:

Date:

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CATASTROPHIC HIGH MEDICAL EXPENSE PATIENT DISCOUNT PROGRAM

APPLICATION

APPLICANTS MUST PROVIDE THE FOLLOWING AND COMPLETE THE ATTACHED FORM.

- Must provide most recent quarter's pay stubs or most recent year tax return statement

INSTRUCTIONS FOR APPLYING:

- Complete and sign this application
- Submit your application and verification documents
    - Mail your application and verification documents to:

Jenine Smith
San Francisco General Hospital
1001 Potrero Ave, Building 10, 5th Floor, Ward 15
San Francisco, CA 94110

- Call (415) 206-3063 for detailed information

APPLICANT INFORMATION

Last name:	First name:
Date of Birth:	Medical Record #:

PERMANENT ADDRESS

Address:	City:
State:	Zip Code:
Country:	Telephone:
Cell Phone:	Email:

ELIGIBILITY & SCREENING

Do you have a medical insurance?	☐Yes ☐No ***If yes, specify:*** ***Provide Insurance card.***
Do you have a pending application with Medi-Cal?	☐Yes ☐No
Total gross monthly income at the time of application:	$ _____ ***Provide most recent quarter (3 mos.) pay stubs or most recent year tax return.***
Do your SFGH medical expenses exceed 120% of your family annual income?	☐Yes ☐No
Have your paid medical costs in the past 12 months exceeded 120% of your family annual income?	☐Yes ☐No ***Provide receipts verifying paid amounts.***

I declare the answers given are true and correct to the best of my knowledge. By submission of this application we may verify your income and ability to pay. I understand that if information is found to be false, I will be held responsible for the full amount of any fee for medical services received from San Francisco General Hospital (SFGH) or the Community Primary Care Clinics.

APPLICANT SIGNATURE:	*DATE:*

PENDING DOCUMENTS – 30 DAY TIME-LIMIT TO SUBMIT	
☐ 3 Months of Pay Stubs or Recent Tax Returns	☐ 3 Months of all bank statements
Comments:	

APPEALS PROCESS FOR DENIED APPLICATIONS

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San Francisco General Hospital • 1001 Potrero Avenue, Ward 15 • San Francisco, CA 94110
Attention: Jenine Smith, Eligibility Manager

Reason for appeal request:

APPEALS DECISION

Charity Program	☐Eligible	☐Ineligible
Discount Program	☐Eligible	☐Ineligible

Decision made by:

Print Name:

Signature:

Date:

Reason for Appeal • Appeals Decision