Financial Assistance Application

Stanford Medicine Children's Health has 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.

Financial assistance is based on need. It might include a discount, or full financial aid. To be considered for any financial assistance, **you must provide all items in the list below**:

- **A completed application**
- **Proof of income**
- **Proof of medical expenses incurred outside of Stanford Medicine Children's Health.**

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 Medicine Children's Health 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 Medicine Children's Health is the closest hospital to the patient's home or place of work; or

B. **Category 2**
Stanford Medicine Children's Health 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 Medicine Children's Health as determined by the Chief Quality and Medical Information Officer of SMCH.

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

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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 list of the POI documentation required for each type of income. You must provide the required documents to be considered for SMCH 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

Every reasonable effort will be made to process your application promptly. Once your application has been reviewed you will receive a letter confirming the outcome.

Mail your completed application, with all the required supporting documentation, to the following address:

Stanford Medicine Children's Health
Attention: Patient Financial Assistance
4700 Bohannon Dr, Menlo Park, CA 94025

Applications and documentation may also be sent by **FAX** to: (650) 497-8610 or sent by **email** to: PFA@stanfordchildrens.org

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Please Print All Information

Date of application: _____

1. FAMILY INFORMATION | please provide names of all people to be considered for financial assistance

Last name	First name	Middle initial	Medical record number	Date of birth (mm/dd/yyyy)
Last name	First name	Middle initial	Medical record number	Date of birth (mm/dd/yyyy)
Last name	First name	Middle initial	Medical record number	Date of birth (mm/dd/yyyy)

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

2. APPLICANT (GUARANTOR) INFORMATION

Relationship to patient	Marital status
☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other: _____	☐ Single ☐ Married/Domestic Partner ☐ Divorced ☐ Separated

Last name	First name	Middle Initial

Date of birth (mm/dd/yyyy)	Number of dependents (other than self & co-applicant)	Ages of dependents	Home phone (xxx) xxx-xxxx	Cell phone (xxx) xxx-xxxx

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?

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If you marked Yes to Married or Domestic Partner: Please complete Section 3.

3. CO-APPLICANT (GUARANTOR) INFORMATION

Relationship to patient				
☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other: _____				
Last name	First name			Middle initial
Date of birth (mm/dd/yyyy)	Number of dependents (other than self & co-applicant)	Ages of dependents	Home phone (xxx) xxx-xxxx	Cell phone (xxx) xxx-xxxx
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.	Is the patient applying for assistance with bills for: Past services: (Indicate dates: _____) Future services: (Indicate dates: _____)	☐ Yes ☐ No
2.	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
3.	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

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4. OTHER COVERAGE QUESTIONS | All answers pertain to the patient

		Check appropriate answer
4.	Is the patient being treated for injuries covered by Workers Compensation? **If yes, please provide the following information:** Name of Workers Comp Carrier: _____ Adjusters Name: _____ Adjusters Phone Number: _____ Injury Date: _____ Claim/Case Number: _____	☐ Yes ☐ No
5.	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
6.	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 Medicine Children's Health to request and/or verify any of the above information as deemed necessary.

Applicant _____ Date _____ Co-Applicant _____ Date _____

Return completed application to:

Stanford Medicine Children's Health
Attention: Patient Financial Assistance
4700 Bohannon Dr, Menlo Park, CA 94025

Or email to:

PFA@stanfordchildrens.org

Or fax to:

Fax: (650) 497-8610

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