SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Department of Public Health
Zuckerberg San Francisco General Hospital
Community Primary Care Clinics
Laguna Honda Hospital and Rehabilitation Center
Population Health Division
Behavioral Health Services

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 apply within one year from date of service.
- Must not be eligible or have exhausted government / non-government payers.
- Must not have any third-party liability.
- Must apply for services received at Zuckerberg San Francisco General Hospital, Community Primary Care Clinics, Laguna Honda Hospital & Rehabilitation Center, Population Health Division, or Behavioral Health Services.
- Must apply for services that have not already been discounted.
- Must provide most recent quarter's pay stubs or most recent year tax return statement.
- Must have a gross family household income at or below 500% federal poverty level for Charity Care consideration.
- Must provide verification of qualified liquid assets for Charity Care consideration.
- Patients or subscribers who receive insurance payments for services received must surrender payments to the San Francisco Health Network to be eligible for financial assistance.

INSTRUCTIONS FOR APPLYING:

- Complete and sign this application.
- Submit your application and verification documents.

For Hospital and Clinic Services, mail your application and verification documents to:

Laguna Honda Hospital and Rehabilitation Center
Admissions and Eligibility Department
375 Laguna Honda Blvd, Rm PG 123
San Francisco, CA 94116

Call the Patient Financial Assistance Department at (415)682-5683 for assistance.

For Behavioral Health Services, mail your application and verification documents to:

BHS Program Member Services Department
1360 Mission St, 2nd Fl
San Francisco, CA 94103

Call the BHS Member Services Department at (888) 246-3333 for assistance.

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.***

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 Zuckerberg San Francisco General Hospital and Specialty Outpatient Clinics, Community Primary Care Clinics, Laguna Honda Hospital & Rehabilitation Center, Population Health Clinic, or Behavioral Health Services.

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 DETERMINATION

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

Denial Reasons:

☐ Non-compliance ☐ Income over 500% FPL
☐ Insured by government or non-government payer
☐ Services were not received at LHH ☐ 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	

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

APPEALS PROCESS FOR DENIED APPLICATIONS

Determination • Appeals

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 one of the following.

For Hospital and Clinic application denials: Patient Financial Assistance Manager, Zuckerberg San Francisco General Hospital, 1001 Potrero Avenue, Ward 15, San Francisco, CA 94110
Patient Access Manager, Laguna Honda Hospital and Rehabilitation Center, 375 Laguna Honda Blvd, RM PG123, San Francisco, CA 94116

For Behavioral Health Services application denials: BHS Member Services Department, 1360 Mission, 2nd Floor, San Francisco, CA 94103

Date:

Reason for Appeal • Appeal Decision

Reason for appeal request:

APPEAL DECISION

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

Print Name:	Signature	Date: