COUNTY OF SANTA CLARA
Health System

FINANCIAL ASSISTANCE APPLICATION FOR PATIENTS WHOSE BILLS FOR HOSPITAL SERVICES WENT TO COLLECTIONS BETWEEN OCTOBER 28, 2018 AND DECEMBER 31, 2021

Complete and return this form along with the required verifying documents by:

- Mailing or personally delivering them to:
  770 S. Bascom Avenue, San José, CA 95128
- Faxing them to: **1-408-494-7848**
- E-mailing them to: **FinancialAssistance@hhs.sccgov.org**

Note: If you choose to e-mail your application, we recommend that you encrypt your message to protect the privacy and security of your personal documents.

To qualify for financial assistance, you must complete all 3 pages of this form and return them to the County within 65 days of the date on the accompanying notice (Document No. 22223). You will then have an additional 150 days to submit the documents specified on the following page to verify your income, identity, and residency. The exact due dates are in the notice.

After we receive your completed form and verifying documents, we will make a decision about whether you qualify for a full or partial discount and let you know in writing. We may call and/or write to you if we have questions about your application.

Your Name (Last, First, Middle)	
Date of Birth (month/day/year)	
Last Four Digits of Your Social Security Number	
E-mail Address	☐ Check here to consent to receive communications regarding this application by secure e-mail.
Mailing Address	
Phone Number	
Preferred Language	

Do you have questions or need help with this form? Call the County of Santa Clara Health System Patient Access Department at 1-408-494-7850 or 1-888-524-3317 (TTY: 711) (8am to 4:30pm, Monday to Friday) or the Health Consumer Alliance at 1-888-804-3536 for free assistance.

Special Circumstances Please check one of the boxes to the right if it applies.	☐ The person whose account was sent to collections is now deceased. ☐ I was transient or homeless at some point between October 28, 2018 and December 31, 2021 (specify dates, to the best of your recollection): _____ _____
Household Status Check the box for each member in your family between October 28, 2018 and December 31, 2021. If the number or status of your family members changed during this time period (for example, if you and your spouse divorced or a child turned 21), please explain in the space provided.	☐ Spouse or domestic partner ☐ Dependent children under 21 years of age, whether living at home or not ☐ Number of children: _____ Total number of individuals, including you: _____ ☐ Changed circumstances (if applicable): _____ _____ _____ _____ _____ _____ _____ _____
Year(s) Your Bill(s) Went to Collections Check the year(s) that your bill(s) went to collections. If you are not sure when your bill(s) went to collections, please call us at 1-408-494-7850 or 1-888-524-3317 (TTY: 711) (8am to 4:30pm, Monday to Friday) for help filling out this form or select "I do not know."	☐ 2018 ☐ 2019 ☐ 2020 ☐ 2021 ☐ I do not know

Income Provide, to the best of your knowledge, your **total gross family income** for each year you had bill(s) that went to collections (the year(s) you checked above). For each year you had bill(s) that went to collections, you need to add the income of each family member you listed above, including yourself. **Do count** pay from work before taxes and deductions, income from operating a business, Social Security payments, unemployment compensation, income from interest and dividends, and income from real estate or personal property. **Do not count** alimony or child support payments. If you are not sure when your bill(s) went to collections, please call us at 1-408-494-7850 or 1-888-524-3317 (TTY: 711) (8am to 4:30pm, Monday to Friday) for help filling out this form, or provide your total gross family income for every year listed.	This was my and my family's: ☐ annual (yearly) income ☐ monthly income Total amount: 2018: $_____ 2019: $_____ 2020: $_____ 2021: $_____
INCOME VERIFICATION This is proof of your total gross family income in the year(s) your bill(s) for hospital services went to collections.	I agree to provide, for each applicable year, a copy my and each of my family member's (choose at least one): ☐ Tax returns ☐ Pay stubs ☐ Other official income documentation ☐ Unsure, I am still searching for documents
IDENTITY VERIFICATION This is proof of your identity (including your photo). Examples include a driver's license, passport, other government-issued ID, or work or school ID.	I agree to provide a copy of my (choose one): ☐ Driver's license or passport ☐ Other government-issued ID ☐ Other photo ID: _____ ☐ Unsure, I am still searching for documents
RESIDENCY VERIFICATION This is proof of your county of residence for the year(s) you checked above. If you are unsure about when your bill(s) went to collections, please provide proof of residence for any time between October 28, 2018 and December 31, 2021. If your county of residence changed during this time, please also check the box to the right.	I will provide a copy of my (choose one): ☐ Rental contract/lease/mortgage statement ☐ Utility bill ☐ Driver's license or vehicle registration ☐ Other: _____ ☐ Unsure, I am still searching for documents ☐ My county of residence changed between October 28, 2018 and December 31, 2021

I affirm that the information I have provided is true and correct.

_____ _____

Date Signature