AHMC Seton Medical Center
AHMC Seton Medical Center Coastside

Date:
Account Number:
Patient's Name:

CHARITY CARE AND FINANCIAL ASSISTANCE APPLICATION

LAST NAME (PATIENT)	FIRST	MIDDLE	SOCIAL SECURITY #	BIRTHDATE
RESIDENCE ADDRESS (FACILITY ADDRESS IF HOMELESS)			HOW LONG	PHONE
CITY	STATE	ZIP	MARITAL STATUS	

SECTION A : MEDICAL ASSISTANCE SCREENING– *Please circle answer "Y" for yes to "N" for no.*

1. Is the patient under age 21 or over age 65? Y / N
2. Is the patient a single parent of a child under age 21? Y / N
3. Is the patient a caretaker or guardian of a child under 21? Y / N
4. Is the patient a married parent of a minor child? Y / N
   If yes, does the patient have a 30-day incapacitation?
5. Is the patient pregnant, or was the admission pregnancy related? Y / N
6. Will the patient potentially be disabled for 12 months? Y / N
7. Is the patient a Victim of Crime? Y / N
8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed? Y / N

SECTION B

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Last Name:	First Name:	Relationship to patient: Self
SSN:	DOB:	
Home Address:		Phone #:
Work Address:		Phone #:
Gross Income:	Circle One - ☐ Hourly ☐ Daily ☐ Weekly Monthly ☐ Yearly	
	Hours Per Week:	
If income is $0/unemployed, what is your means of support?	☐ Living on Savings/Annuity ☐ Live with parent/family/friends Homeless ☐ Shelter	

SPOUSE

Last Name:	First Name:	
SSN:	DOB:	
Home Address:		Phone #:
Work Address:		Phone #:
Gross Income: $	Circle One - ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
	Hours Per Week:	

LAST NAME (GUARANTOR IF DIFFERENCE FROM ABOVE)	SOCIAL SECURITY #	BIRTHRATE
EMPLOYER OF GUARANTOR (NAME AND FULL ADDRESS		
PHONE		MONTHLY GROSS PAY $
OTHER EMPLOYER (NAME AND FULL ADDRESS		
PHONE		MONTHLY GROSS PAY $
IF UNEMPLOYED, NAME OF LAST EMPLOYER AND FULL ADDRESS		
		LAST EMPLOYMENT DATE

DEPENDENT FAMILY MEMBERS (IF MORE SPACE IS NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER)	BIRTHDATE	RELATIONSHIP	EMPLOYED BY	
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

☐RENT HOME ☐ OWN HOME			*OTHER MONTHLY INCOME* $ *SPECIFY SOURCE*	
OWED TO OTHERS TO WHOM OWED	PRESENT BALANCE	MONTHLY PAYMENT	**ASSETS** BANK NUMBER &ACCOUNT NUMBER	ACCOUNT BALANCE
RENT/MORTGAGE			CHECKING	
UTILITIES			SAVINGS OR CERTIFICATE	
FOOD			403(B) OR 401(K)	
AUTO LOAN			STOCKS & BONDS	
	PRESENT BALANCE	MONTHLY PAYMENT	ASSETS BANK NUMBER &ACCOUNT NUMBER	ACCOUNT BALANCE
CREDIT CARDS			IRA	
			AUTO (YEAR & MAKE)	
			AUTO (YEAR & MAKE)	
OTHER OBLIGATIONS (CHILD SUPPORT, ALIMONY, INSURANCE PAYMENTS)			RESIDENCE MARKET VALUE	
ADDITIONAL INFORMATION			INSURANCE CASH VALUE	
BILLS OWED TO OTHER MEDICAL PROVIDERS			OTHER ASSETS (DESCRIBE. E.G., SECOND HOME)	
COST OF PRESCRIPTION MEDICATION(S)				
TOTAL DEBTS			**TOTAL ASSETS**	

I CERTIFY THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE AND COMPLETE. YOU ARE HEREBY AUTHORIZED TO CHECK MY CREDIT HISTORY IN ORDER TO EVALUATE THIS APPLICATION FOR FINANCIAL ASSISTANCE CONSIDERATION.

SIGNATURE	DATE

1900 Sullivan Ave.
Daly City, CA 94015

In order for this application to be considered for Financial Assistance, ALL of the following documents are required, if applicable

►Completed and signed Financial Assistance Application form

►A copy of most recent Federal Income Tax return with W-2's and Schedules

►A copy of current pay stubs (13 weeks)

►A copy of social security, disability, or unemployment checks or award letter

►A copy of a state AHCCS/Medi-Cal Decision/Denial Notice aka Notice of Action letter. You can obtain this by contacting the Medi-Cal office in the area in which you live. All potentially eligible patients must provide a valid "Notice of Action" from AHCCS/Medi-Cal stating completion of the application and the reason for acceptance or denial. Any Notice of Action stating a failure to provide information or failure to participate in the interview will not be accepted in consideration of this Application for Financial Assistance.

►**3 months** of current bank statements (checking and savings)

Please return your completed application with all requested forms to the following address within 10 days.

Seton Medical Center
1900 Sullivan Ave.
Daly City, CA 94015
Attn: Financial Advisor

Contact the Financial Advisor at 650-991-6614 if you have any questions.

Please be advised this in not a guarantee that financial assistance will be awarded; and payments should continue on a regular basis until a determination has been made. Your application and the information provided will be reviewed and verified and a decision will be provided to you in writing.

Thank you for your cooperation. We look forward to being of assistance to you to resolve your account.

Return by this Date:
Account Number:
Account Balance: