

SMMC Financial Assistance Program Application

The information you provide on this application will be used to check which health coverage program is right for you. Available programs include Charity Care, Discounted Health Care (DHC), and Financial Hardship Assistance (FHA). These are not insurance plans.

All programs require you to provide proof of income and identity. Insured patients with high medical costs applying for DHC must also submit proof of out-of-pocket expenses. The FHA program additionally requires proof of assets and hardship. Eligibility for each program is different, and not everyone will qualify.

How to submit this application:

- ☐ **By phone:** Call the Health Coverage Unit at **650-616-2002**
- ☐ **By email:** Info-HCU@smcgov.org
- ☐ **By mail:** Health Coverage Unit, 801 Gateway Boulevard, Suite 100, South San Francisco, CA 94080

Questions?

Call us or visit smchealth.org/health-insurance for more information.

Income Levels to Qualify

Eligibility is based on the Federal Poverty Level (FPL). The FPL is a measure of income used to determine eligibility for various assistance programs and benefits*. The chart shows the FPL annual income limits by family size for each program.

Family Size	138% FPL Charity Care	400% FPL DHC
1	\$21,597	\$62,600
2	\$29,187	\$84,600
3	\$36,777	\$106,600
4	\$44,367	\$128,600
For each additional family member add:	\$7,590	\$22,000

Effective 1/1/2025

*For Financial Hardship Assistance, there is no set income limit and other factors are used to determine eligibility.

Applicant Information			
Name:		MRN:	
Date of birth:	SSN:	Phone:	
Current address:		Other Phone:	
City:	State:	ZIP Code:	
Household Information			
Family size:		Family Gross Monthly Income	\$
Visit Information			
Date (or dates) of medical visit with a bill needing coverage:			
Is this visit due to a work-related injury or automobile accident?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have public or private medical insurance or coverage through a Federal, State, or County program (e.g., HMO/PPO, travel insurance, Medicare, Medi-Cal, Covered CA, etc.)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, why do you need financial assistance with this visit?			
<input type="checkbox"/> Coinsurance <input type="checkbox"/> Deductible <input type="checkbox"/> Share of Cost	<input type="checkbox"/> Date of service outside of coverage period <input type="checkbox"/> Other _____		
Financial Hardship Assistance (FHA)			
Any patient may apply for a waiver or discount due to the patient's inability to pay.			
Are you experiencing one or more of these specific financial hardships listed below? If yes, check all that apply.			
<input type="checkbox"/> Death of a family member (living in household or claimed on taxes) - within last 6 months <input type="checkbox"/> Loss of job or reduction of income <input type="checkbox"/> Illnesses or accidents <input type="checkbox"/> Loss of housing - foreclosure, eviction, natural disaster, etc. <input type="checkbox"/> Financial liability - bankruptcy, liens, lawsuits, etc.			
Please detail how the hardship selected above is making it difficult to meet financial obligations.			

SMMC will screen all patients with a balance due for financial assistance eligibility for services received at SMMC hospital or clinics.

DHC Acknowledgements

1. To qualify for DHC, my household income must be 400% of the Federal Poverty Level or lower.
2. I will not qualify if enrolled in government or private insurance unless I have “high medical costs”. High medical costs are defined as having annual out-of-pocket expenses for medical care that is more than 10% of the patient’s current family income OR income in the prior 12 months (whichever is lower).
3. I must report within 10 days any changes in income or health insurance/coverage status.
4. In addition to SMMC hospital and clinics, DHC can be used at pre-approved associated pharmacies (list available upon request).
5. If approved for DHC, I will receive a 65% discount off regular charges.

Charity Care Acknowledgements

1. If I have a balance due that doesn’t qualify for payment from other payers, I’ll be considered for Charity Care.
2. To qualify for Charity Care, my household income must be 138% of the Federal Poverty Level or lower.
3. If approved for Charity Care, the patient balances for my approved visits will be waived.
4. I understand that Charity Care is only available if I am subsequently unable to be enrolled in a health coverage program.

FHA Acknowledgements

1. Any patient who has a financial hardship and cannot pay for the services received at the hospital or clinics will be considered for FHA.
2. If approved, patients get a discount of 100% and will not be responsible for the balance due.

DHC, Charity Care and FHA Acknowledgements

1. The SMMC Financial Assistance Programs application may be submitted at any time.
2. I must submit proof within 45 days of my application date of my household income including: a recent employment paystub, government check stub or letter (unemployment or disability), or federal tax forms (photocopies only – originals will not be returned).
3. If I provide false information on my application or verifications, I will be disqualified from financial assistance. I may then be billed retroactively for all services previously covered or discounted. Providing false information to get benefits is a reportable offense.
4. I will be told in writing if I qualify for DHC, Charity Care or FHA. I will get the notice within 45 days after the County receives my completed application. The notice will include information about how to appeal a denial.

I declare the above information is true and correct. **My signature means I have read and understood each statement above and agree to be enrolled in DHC, Charity Care or FHA.**

Signature of applicant:

Date: