San Mateo Medical Center
A County System of Healthcare

Charity Care Application

Step 1:

Do you need financial assistance for any of the following types of services at San Mateo Medical Center (SMMC)?

Emergency Room (ER) Visit – SMMC only	❑ Yes	❑ No	Date(s) of Service _____
Surgery – Transferred from SMMC's ER	❑ Yes	❑ No	Date(s) of Service _____
Inpatient Stay – Transferred from SMMC's ER	❑ Yes	❑ No	Date(s) of Service _____

If Yes to any of the above, continue with application. If No to any of the above, you are not eligible for Charity Care.

Step 2:

Is this visit due to a work-related injury or automobile accident? ❑ Yes ❑ No

Do you have public or private medical insurance or coverage through a Federal, State, or County program (e.g. HMO/PPO, Medicare, Medi-Cal, Healthy Families, Healthy Kids, etc.)? ❑ Yes ❑ No

If No to the questions in Step 2, continue with the application. If yes to these questions, you are not eligible for Charity Care.

Patient Last Name	Patient First Name	MRN	Date of Birth
			MM / DD / YY

Family Monetary Assets (not including exemptions)	
Cash	$_____
Checking Account	$_____
Savings Account	$_____
Money Market Fund	$_____
Certificate(s) of Deposit	$_____
Annuities	$_____
Stocks/Bonds	$_____
Mutual Funds (Not part of retirement or Deferred compensation plan)	$_____
Total Family Monetary Assets	**$**_____

Family size	_____
Family Gross Monthly Income	**$**_____

I acknowledge I have received copies of the Financial Assistance Programs brochure. I understand that if I don't qualify for Charity Care, I may qualify for another program.

I declare under penalty of perjury that the above information is true and correct. Further, by signing below, I hereby authorize County personnel, agents or contractors, to verify and/or investigate my eligibility. Such investigation/verification may include the obtaining and use of information and documents possessed by other public and private agencies, including, but not limited to, records of the Department of Child Support Services. Applicant/Guardian will be notified by mail, whether application is approved or denied.

Patient Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

FOR DEPARTMENT USE ONLY

Date of Eligibility Determination: _____ ❑ **Approved** ❑ **Denied**

Staff Signature: _____ **Date:** _____

San Mateo County Charity Care Program Application

Eligibility Criteria
You must meet the following criteria to be eligible for the program:

- Your household income is at or below 100% of the Federal Poverty Level (FPL).
- Your household monetary assets are at or below $10,500. This includes checking, savings and investment accounts. This does not include retirement accounts or deferred-compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans.
- You must have received one of the following types of services: SMMC ER visit, Inpatient transfer from SMMC's ER, or Surgery transfer from SMMC's ER.
- Your Charity Care application is submitted within 150 days from initial issuance of a bill.

If you do not meet these criteria, please contact Patient Accounting Department at 573-2525.

Documentation Required

- Copies of your pay stubs for the three months preceding the admission date or ER visit, or copies of your most recent signed federal tax return.
- Copies of other documents to verify income. This includes, but it is not limited to, letters from disability, social security or unemployment offices.
- Copies of three concurrent bank statements for the three months preceding the admission date or ER visit. This includes checking, savings and investment accounts. This does not include retirement accounts or deferred-compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans.

Do not send originals. Send photocopies only. Originals will not be returned.

Notification of Eligibility Determination

- The applicant has 45 days from the application date to provide required documentation. If it is not provided within 45 days, the application will be denied. The applicant will receive a written notice that the application has been denied based on his/her failure to provide necessary verifications.
- Individuals who apply for Charity Care will be informed in writing if they qualify. The letter will be provided to the applicant within 45 days after receipt by the County of a complete application and it shall provide information about the right to appeal a denial.

Patient Right to Appeal
If you are denied eligibility for Charity Care, or wish to request a waiver or reduction of co-pays, fees or charges, you have the right to a two-step appeals process that allows you to present evidence of eligibility or argue special circumstances based on your inability to pay. The first appeal step is an "individual eligibility review" (IER) to appeal any financial and non-financial issues relating to eligibility and ability to pay. If you are not satisfied with the decision from the IER process, you can appeal to the "eligibility and financial review committee" (EFRC).

An applicant may appeal the denial of Charity Care and must submit written request within 60 business days of receiving their denial determination to: **Director of Patient Access, San Mateo Medical Center, 222 W. 39th Avenue, San Mateo, CA 94403.** The applicant must submit the following items:

- Copy of complete application
- Statement setting forth the basis of the appeal

If you have any questions regarding this application you can contact us by mail at: San Mateo Medical Center, Attn: Ana Rivera, Patient Access Supervisor, 222 W. 39th Ave., San Mateo, CA 94403. Phone: 650-573-2574