

## San Joaquin County Medical Financial Assistance and Eligibility

Enclosed is an application for assistance programs for medical costs provided by San Joaquin County. The eligibility process and financial screening will determine if you are eligible for a variety of federal, state or local assistance programs. If you are eligible, these programs may provide coverage for basic medical services.

The current programs are:

- Medical Assistance Program (MAP)
- Charity Care
- Catastrophic Charity
- Discount Program
- Prompt Pay Discount

This application must be completely filled out and signed. Please bring all documents that apply to your situation as only a full understanding of your financial status will allow us to correctly determine your eligibility for medical coverage programs(s).

During your interview, you may be asked to bring in additional documents not on this list. If documentation needed is not provided, your application will be considered incomplete and will be denied. The documents requested will establish your eligibility for programs based on legal residency, income and for some programs, financial assets. Completing the application process will assist you in identifying programs that will help you meet your medical needs and provide coverage of medical expenses.

### **REQUIRED DOCUMENTATION - Identity, Residency, Finances**

1. **US Government State issued photo I.D.**
2. **Social Security Card**
3. **Permanent residency card**
4. **Proof of residency** (*utility bill, even if under a different name*).
5. Mortgage statement/rent receipts or rental contract.
6. If you are living with someone, bring a **notarized letter from that person explaining your living arrangements and how they are providing assistance, or bring that person with you.**
7. Pay stubs-last four for all sources (*employment, unemployment, work comp, disability, etc*)
8. If you, or your spouse, are unemployed you will need to file an unemployment claim (800-300-5616) and bring in a copy of your EDD (*status of employment*) or most current Social Security report of earnings, current retirement check amount receiving or Social Security Retirement
9. If you are on general relief, bring in a report (SJ64) from your eligibility worker showing current status and case number; or Food Stamps "Passport to Services" printout.
10. If you are residing in a residential rehab program, bring in a letter from the program indicating your admission date and your expected date of completion.
11. Bank statements – last 3 months (all pages)
12. Complete income tax return; personal and business taxes. (*Most recent, including all W-2's and schedules*) If you do not have a copy, call 1-800-829-1040 for a tax transcript.
13. Proof of employer offered/not offered benefits on company letterhead.
14. Medi-cal/SSI/SSDI Case Documentation; Pending and Denial (*if applicable*).
15. Divorce or Legal Separation Papers (*if applicable*)
16. Asset documentation (example: vehicle registration, IRA, 401K, stocks, bonds, mutual funds, whole life insurance policy with proof of current cash-out value, and any employer issued retirement accounts). (*if applicable*)

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## Application

### DEMOGRAPHIC and FINANCIAL INFORMATION Schedule of Current Income and Expenditures

Patient Name:	Spouse Name:
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner	
Address:	
Home Phone:	Cell Phone:
Spouse Cell Phone:	
Social Security Number: <i>(Patient)</i>	Social Security Number: <i>(Spouse)</i>
Date of Birth: <i>(Patient)</i>	Date of Birth: <i>(Spouse)</i>

List all dependents you support, and currently living with you:

Name	Date of Birth	Age	Relationship

Possible Links to Categorical Funding: *Circle one, if applicable.*

**NOTE:** The requested information below will be used solely to determine linkage to available funding programs and will not impact your clinical care.

- Are you or will you be disabled for more than 1 year?
Y    N
- Are you a veteran of the armed forces?
Y    N
- If female, have you been diagnosed with breast or cervical cancer?
Y    N
- If female over 40, do you plan on having a mammogram?
Y    N
- If female over 25, do you plan on having a Pap test?
Y    N
- Are you seeking assistance for reproductive health needs *(pregnancy or contraceptive request)*?
Y    N
- Are you seeking assistance for a child/dependant under the age of 21 with a mental health-related condition?
Y    N
- Do you or your family members have any other conditions for which you are seeking treatment or need assistance?
Y    N

## Employment Information:

Full Time   
  Part Time   
  Self-Employed   
  Retired

Employer:	Occupation: Seasonal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Name & Title:	Phone:
If self-employed, give name of business:	

Spouse's employer: <input type="checkbox"/> Full time <input type="checkbox"/> Self <input type="checkbox"/> Part Time <input type="checkbox"/> Retired	Occupation:
Contact Name & Title:	Phone:
If self-employed, give name of business:	

## Income and Assets:

<b>Monthly Income:</b>	Patient	Spouse
Gross pay from employment	\$ _____	\$ _____
Self Employment Income	\$ _____	\$ _____
Other income: _____	\$ _____	\$ _____
Social Security/Disability	\$ _____	\$ _____
Alimony, support payments	\$ _____	\$ _____
<b>Total current monthly income</b>	<b>\$ _____</b>	<b>\$ _____</b>

**Please provide your best estimate of the value of any homes, cars or similar assets. Also, indicate how much debt you currently have. Assets may impact eligibility for some programs, and for some programs are disregarded entirely.**

### Assets:

- a. Primary Home \$ \_\_\_\_\_
- b. Other homes or properties \$ \_\_\_\_\_
- c. Automobiles \$ \_\_\_\_\_
- Make: \_\_\_\_\_ Model: \_\_\_\_\_
- Make: \_\_\_\_\_ Model: \_\_\_\_\_
- d. Checking/Savings Accounts \$ \_\_\_\_\_
- Bank: \_\_\_\_\_ Amount: \_\_\_\_\_
- Bank: \_\_\_\_\_ Amount: \_\_\_\_\_
- e. Investments/other (specify) \$ \_\_\_\_\_

**Debts:**

- a. Amount owed on mortgages \$ \_\_\_\_\_
- b. Amount owed on automobiles \$ \_\_\_\_\_
- c. Amount owed on credit cards \$ \_\_\_\_\_
- d. Other (*specify*) \_\_\_\_\_ \$ \_\_\_\_\_

**Monthly Expenses:**

- Rent or house payment \$ \_\_\_\_\_
- Food \$ \_\_\_\_\_
- Utilities (*phone, electricity, water, etc.*) \$ \_\_\_\_\_
- Automobile/Transportation (*Payment/Gas, etc.*) \$ \_\_\_\_\_
- Insurance (*home, automobile, life, etc.*) \$ \_\_\_\_\_
- Credit cards/other debt \$ \_\_\_\_\_
- Other \_\_\_\_\_ \$ \_\_\_\_\_

**My/our signature on this form gives San Joaquin County authorization to verify the information on this application including my/our permission to contact employers and to check my/our credit history. I swear under penalty of perjury that the foregoing information is true and correct to the best of my knowledge.**

Date:	(Signature of Applicant or Guarantor)
Date:	(Signature of Spouse)