UCSF Benioff Children's Hospital
Oakland

Children's Hospital & Research Center Oakland, d/b/a UCSF Benioff Children's Hospital Oakland Community Care Application

Instructions

As part of our commitment to serve the community, Children's Hospital & Research Center Oakland, d/b/a UCSF Benioff Children's Hospital Oakland (BCHO or the Hospital), provides financial assistance to patients/guarantors who are not eligible for State or Federal programs, uninsured or underinsured. This program is Community Care.

To determine if a patient/guarantor qualifies for Community Care, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please provide the following information and copies of information with your financial assistance application:

1. Statement of Financial Condition
2. Documents to verify income:

Please provide one or more of the following:	**Please provide a copy of one of the following:**
A. IRS Form W-2, Wage and Earnings B. Last two pay check stubs for all household earnings; and/or C. Bank statement that contains income information.	A. Government Assistance, Social Security or Workers' Compensation; or B. Unemployment compensation letter; or C. Income tax return for previous year.

In the event income verification that is unavailable, please contact our office for further instructions. Applications without income verification are considered incomplete and will not be processed. For assistance in completing this application, please contact UCSF Benioff Children's Hospital Oakland **(510) 428-3485**. Monday through Friday from 8:00 a.m. to 4:00 p.m.

Please return the application and verification of income documents within 14 calendar days to:

Patient Accounting Office-Community Care
UCSF Benioff Children's Hospital Oakland
6425 Christie Avenue
Suite 120
Emeryville, CA 94608

We will notify you of your eligibility following receipt and review of all necessary information. The notification will be mailed to the mailing address you have provided on the Community Care Application

UCSF Benioff Children's Hospital Oakland
Community Care Program
STATEMENT OF FINANCIAL CONDITION

Patient Name _____ **Account No:** _____

Guarantor Name _____ **Guarantor Name** _____

Address _____

Phone _____

FAMILY STATUS: List all dependents in the household

Name _____ Age_____ Relationship _____

Name _____ Age_____ Relationship _____

Name _____ Age_____ Relationship _____

Name _____ Age_____ Relationship _____

Name _____ Age_____ Relationship _____

EMPLOYMENT AND OCCUPATION

Employer _____ Position _____

Contact Person_____ Telephone _____

If Self-Employed, Name of Business _____

Spouse Employer _____ Position _____

Contact Person_____ Telephone _____

If Self-Employed, Name of Business _____

CURRENT MONTHLY INCOME		**Guarantor**	**Guarantor**
	Gross Pay (Before deduction)		
Add	Income from Operating Business (if Self-Employed)		
Add	Other Income:		
	Interest and Dividends		
	From Real estate or Personal Property		
	Social Security		
	Other (specify)		
	Alimony or Support Payments Received		
Subtract	Alimony, Support Payments Paid		
Equals	Current Monthly Income		
Total Monthly Income (Combine both guarantors)			

FAMILY SIZE

Total Family Members: (Add patient, guarantors and dependents form above) _____

By signing this form, I agree to allow UCSF Benioff Children's Hospital Oakland to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I am also required to provide the documents outlined in the UCSF Benioff Children's Hospital Oakland Financial Assistance Application Instructions within 14 days.

_____ _____

Signature of Guarantor (Handwritten signature required) **Date**

_____ _____

Signature of Guarantor (Handwritten signature required) **Date**