SAN MATEO COUNTY HEALTH
HEALTH COVERAGE UNIT

225 37th Avenue
San Mateo, CA 94403
smchealth.org

SMMC Financial Assistance Program Application

The information you provide on this application will be used to evaluate your eligibility not only for Charity Care and the Discounted Health Care (DHC) programs, but also for other health coverage programs. These include Medi-Cal, Covered California, Access and Care for Everyone (ACE), Kaiser Community Health Care (CHCP), amongst others. Eligibility for each program varies, and not all applicants will qualify.

To apply for a health coverage program or if you have questions about your eligibility, call the Health Coverage Unit at **650-616-2002**, visit smchealth.org/health-insurance, or submit your application via **email:** Info-HCU@smcgov.org or **mail:** Health Coverage Unit, 801 Gateway Boulevard, Ste. 1, South San Francisco, CA 94080.

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(s) of medical bill(s) that need to be covered:		
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, travel insurance, Medicare, Medi-Cal, Covered CA, etc.)?	☐ Yes	☑ No

If yes, why do you need financial assistance with this visit?

☐ Coinsurance
☐ Deductible
☐ Date of service outside of coverage period
☐ Other _____

Income Levels to Qualify

Eligibility is based on the Federal Poverty Level (FPL), determined by family size and annual income.

Family Size	138% FPL Medi-Cal/Charity Care	200% FPL ACE	300% FPL Kaiser CHCP	400% FPL DHC	600% FPL Covered California
1	$20,783	$30,120	$43,740	$60,240	$90,360
2	$28,208	$40,880	$59,160	$81,760	$122,640
3	$35,632	$61,640	$74,580	$103,280	$154,920
4	$43,056	$62,400	$90,000	$124,800	$187,200
For each additional family member add:	$7,425	$10,760	$16,140	$21,520	$32,280

Effective 1/1/2024

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San Mateo Medical Center (SMMC) patients who do not qualify for other health coverage programs may qualify for either the Charity Care or DHC programs.

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, but only after efforts have been exhausted to enroll me into an appropriate health coverage program.
2. To qualify for Charity Care, my household income must be 138% of the Federal Poverty Level or lower.
3. Charity Care can only be used at SMMC facilities. Charity Care is not an insurance program.
4. If approved for Charity Care, the patient balances for my approved visits will be waived.

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 exceed the lesser of 10% of the patient's current family income or family income in the prior 12 months.
3. DHC can only be used at pre-approved SMMC facilities and associated pharmacies (list available upon request). DHC is not an insurance program.
4. If approved for DHC, I will receive a 65% discount off regular charges.

Charity Care and DHC Acknowledgements

1. I must apply for Medi-Cal or other programs if asked to do so.
2. The Financial Assistance Programs application must be submitted within 6 months from the visit date. Applications received after 6 months will be considered on a case-by-case basis.
3. 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 from last year (photocopies only – originals will not be returned).
4. If the information I provide is not accurate, I will be disqualified for Charity Care and DHC and I may be billed retroactively for all services previously covered by these programs.
5. Providing false information to wrongfully get benefits may be a reportable offense.
6. I will be told in writing if I qualify for Charity Care or DHC. 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. By signing below, I authorize County personnel, agents, or contractors, to verify and/or investigate my eligibility. Such investigation/verification may include obtaining and using information and documents possessed by other public and private agencies. **My signature indicates I have read and understood each statement above and agree to be enrolled in Charity Care or DHC.**

Signature of applicant:	Date:

Revised 9/16/2024