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. **Proof of citizenship or permanent residency (birth certificate or residency alien 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. Application summary for Covered California; if applicable.
15. Medi-cal/SSI/SSDI Case Documentation; Pending and Denial *(if applicable).*
16. Divorce or Legal Separation Papers *(if applicable)*
17. 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:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner

Address:	
Home Phone: Cell Phone:	Spouse Cell Phone:
Social Security Number: *(Patient)*	Social Security Number: *(Spouse)*
Date of Birth: *(Patient)*	Date of Birth: *(Spouse)*

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? ☐ Yes ☐ No
Contact Name & Title:	Phone:
If self-employed, give name of business:	

Spouse's employer: ☐ Full time ☐ Self ☐ Part Time ☐ Retired	Occupation:
Contact Name & Title:	Phone:
If self-employed, give name of business:	

Income and Assets:

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

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 _____ $ _____

By signing this document, I give San Joaquin County authorization to verify any information contained on this form. I give San Joaquin County authorization to obtain any other information to determine my financial liability. I declare under perjury the information contained on this form is true and correct.

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