University of California, San Francisco
1701 Divisadero St, Rm 280
San Francisco, CA 94115

Tel: (415) 353-7546
(800) 497-0244
Fax: (415) 353-7543

URL: https://dermpath.ucsf.edu

Email: DPInfo@ucsf.edu

UCSF Dermatopathology & Oral Pathology Service

Please find the enclosed Financial Assistance Application. You may return the completed Financial Assistance Application to:

UCSF Dermatopathology & Oral Pathology Service
Attn: Client Services
1701 Divisadero St, Ste 280
San Francisco, CA 94115

Or email completed Applications to:
DPinfo@ucsf.edu

Note: Income verification must be included for the application to be processed. Please provide all information to avoid delays in processing. Application will be returned if supporting documentation is missing. Acceptable proof of income includes:

- □ Copy of most recent (2 months) pay stubs for applicant (& co-applicant).
- □ Copy of current year W-2 or 1099 earnings statements for applicant (& co-applicant).
- □ Copy of signed current year's Income Tax Return for applicant (& co-applicant).
- □ Copy of current Social Security Allotment letter and/or other proof of income.

**Bank statements will not be accepted as proof of income.

If non-US citizen:

- □ Copy of valid Legal Permanent Resident Card is required.

If you have any further questions and/or concerns, please contact Client Services at 415-353-7270.

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Financial Assistance Application

1. Patient Information

Last Name	First Name	Middle Initial	Case / Account Number

2. Applicant Information

Marital Status
□ Married □ Single □ Separated

IF MARRIED, SECTION 3 MUST BE COMPLETED

Last Name	First Name	Middle Initial	U.S. Citizen (See #6)
			□ Yes □ No

Date of Birth	No. Dependents (under age 21, other than self & spouse)	Age(s) of Dependent(s)	Home Phone
			( ) -

Mailing Address, City, State, Zip	Cell Phone
	( ) -

Current Employer	Work Street Address, City, State, Zip	Position

3. Co-Applicant Information

Relationship to Patient
□ Self □ Spouse □ Parent

□ Other _____

Last Name	First Name	Middle Initial	U.S. Citizen (See #6)
			□ Yes □ No

Date of Birth	No. Dependents (under age 21, other than self & spouse)	Age(s) of Dependent(s)	Home Phone
			( ) -

Mailing Address, City, State, Zip	Cell Phone
	( ) -

Current Employer	Work Street Address, City, State, Zip	Position

Updated 5/10/2022

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4. Income Information (Supporting documentation required. To list additional income, use back of this application)				**Combined Monthly Income**
Select	**Monthly Income Sources**	**Applicant**	**Co-Applicant**	
	Employment Income	$	$	$
	Social Security	$	$	$
	Alimony / Child Support	$	$	$
	Other: *(Unemployment, Disability, Pension, etc.)*	$	$	$
			Total Combined Monthly Income	$

5. Assets (To list additional income, use back of this application)		
Checking / Money Market / Savings Accounts:		
Bank Name:	Branch / Address, City, State, Zip	
1.		$
2.		$
Other Cash Assets:		**$**
	Total Asset Value	$

6. Supporting Documentation (REQUIRED)

Application will be returned if supporting documentation is missing. Acceptable proof of income includes:

- □ Copy of most recent (2 months) pay stubs for applicant (& co-applicant if applicable).
- □ Copy of current year W-2 or 1099 earnings statements for applicant (& co-applicant if applicable).
- □ Copy of **signed** current year's Income Tax Return for applicant (& co-applicant if applicable).
- □ Copy of current Social Security Allotment letter and/or other proof of income (**section 4**).

At least one of the listed documents is required. Please do not hesitate to contact us with any questions or concerns regarding this requirement.

****Bank statements will not be accepted as proof of income.**

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7. Comments

Enter any additional information relevant to your request not reflected on this application:

8. Signature and Date (REQUIRED OF APPLICANT & CO-APPLICANT)

I certify that all information is true and complete, and hereby authorize UCSF Dermatopathology & Oral Pathology Service to request a credit check report and/or verify any of the above information as deemed necessary. I understand that incomplete applications will be returned to the applicant and not processed. I understand that I may be required to complete a new application for future services. I agree to notify UCSF Dermatopathology & Oral Pathology Service of any changes to my (or my Co-Applicant's) financial circumstances that may affect my eligibility for financial assistance.

_____
Applicant Name (Printed)

_____
Applicant Signature Date

_____
Co-Applicant Name (Printed)

_____
Co-Applicant Signature Date

To Be Completed by UCSF Only:

_____
UCSF Supervisor Name (Printed)

_____
UCSF Supervisor Signature Date

Effective Dates:_____ to _____
Start End