



San Joaquin General Hospital / A Division of San Joaquin County Health Care Services

Medical Assistance Program (MAP) REQUIRED DOCUMENTATION

Enclosed is a MAP application for the hospital program. If eligible, the hospital may assist you with your hospital account. This application must be completely filled out and signed. Please bring all documents that apply to your situation. 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. Failure to apply for this program will result in you becoming completely responsible for your account. **You have 60 days to provide all information requested.**

1. **US Government State issued photo I.D.** (required)
2. **Social Security Card** (required)
3. **Permanent residency card**
4. **Proof of naturalization (citizenship papers/passport)**
5. Sponsorship papers INS form I-797 and their financial records (if applicable).
6. Proof of residency (i.e., utility bill, even if under a different name).
7. Mortgage statement/rent receipts or rental contract.
8. If you are living with someone, please bring **a notarized letter from that person explaining your living arrangements of how they are providing assistance, or bring that person with you.**
9. Pay stubs-last four (employment, unemployment, work comp, disability)
10. If you or your spouse are unemployed, or self employed, 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 report or earnings or current retirement check amount receiving.
11. If you are on general relief, bring in a report (SJ64) from your eligibility worker showing current status and case number.
12. 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.
13. Bank statements – last 3 months (mailed version) all pages.
14. 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).
15. Complete income tax return. (Last years or most recent to include all W-2's and scheduled) 1-800-829-1040 tax transcript.
16. Proof of employer offered/not offered benefits on company letterhead.
17. Proof of Medi-cal denial, (if applicable).
18. A credit report may be required.
19. Social security report of earnings (if applicable).
20. Divorce/separation document (if applicable).

Post Office Box 1020 • Stockton • California 95201 • (209) 468-6000



**SAN JOAQUIN GENERAL HOSPITAL
MEDICAL ASSISTANCE PROGRAM
APPLICATION**

**FINANCIAL EVALUATION FORM
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			
Medical Record #:		Medical Record #:	
Address:			
Phone:		Message/Other 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: Inform the patient that the requested information below will be used solely to determine linkage to available funding programs and will not impact the clinical care they receive at the hospital.

- 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 o need assistance? Y N

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 General Hospital 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 Patient or Guarantor)
Date:	(Signature of Spouse)

Interviewed by:	Date:
Approved For: <input type="checkbox"/> MIA <input type="checkbox"/> CHIP	Co-Payment: (<i>circle one</i>) A B C
Catastrophic Charity Adjustment: (<i>circle one</i>) <input type="checkbox"/> 20% 30% 40% 50% 60%	
<input type="checkbox"/> Denied	Reason: