CSF Medical Non-Profit Foundation Application

3811 Mt. Vernon Ave. Bakersfield, CA 93306
O: 661.404.4748 | O: 661.333.5746
F: 661.327.7255

Economic assistance provided by CSF Medical Non-Profit Foundation will be exclusively for *surgical* services.

Criteria to qualify:

- No medical health insurance.
- Low income. Federal Poverty Level (FPL) per person is $12,060 per year; per couple it's $16,240. Add $4,180 per additional member in the household.
- Have a minimum of 10% of the value of your surgery and for every employed adult in the household an additional 5% must be included in surgery cost before applying.
- To submit your application your monthly and annual income must be verifiable.
- You will need to have your consultation and surgery in Bakersfield, CA.

Requirements:

1. Copy of patients Identification.
2. Must have a medical diagnosis from a family doctor or specialist. If the patient does not have one, we recommend calling CSF Foundation to receive specialized information at (661) 404-4748.
3. Employment verification for all who work in the household.
4. Last 3 months of check stubs for everyone who works in the household.
5. Most recent rent receipts.
6. Utility receipt (showing residency address).
7. Checking and Saving bank account statements for the last 3 months. If you do not have any bank accounts, please write a note stating so. Make sure to write your name, date, and sign the document.
8. Most recent tax returns for all the tax payers of the household.

Please make sure to send copies; original documents will not be accepted. Should you have any questions, please contact our office Monday through Friday from 9:00 a.m. to 5:00 p.m. and ask to speak with Abby Hannah, Executive Assistant. Thank you!

Federal Poverty Level (FPL)

A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine your eligibility for certain programs and benefits. The Federal Guideline amount per person is $12,060; per couple it's $16,240. Add $4,180 per additional member in the household.

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Applicant information

1. **Complete the following personal information for applicant soliciting assistance.**

Today's Date:	Month: Day: Year:
Sex:	◯ Male ◯ Female
First and Last Name:	
Birthdate:	Month: Day: Year:
Home phone number (including area code):	
Cell phone number (Including area code):	
Address (street, apt.#, etc.):	
City, State, and Zip Code:	
Mailing address (If different):	
City, State, Zip Code:	
Job or Occupation:	
Marital Status (single, married, widow, divorced):	
Email Address:	
Type of surgery needed:	
Primary Physician(s):	

Initials _____

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For CSF Medical Non-Profit Foundation offices use only

Notes and Comments:

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2. Please send clear copy of your picture ID (Driver's license, Passport, etc.) and recent proof of address (utility bill or proof of rent or mortgage).

3. **Household members:**

Full Name	Relation to Applicant	Date of Birth
1)		
2)		
3)		
4)		
5)		
6)		
7)		

For additional household members, please attach another page to the back.

Income and Work Status

4. State all sources of income in the household. Please send the last 3 months of income, and last year's tax return for each member in the household. IMPORTANT: Complete the employment verification form at the end of this application for each member of the household that is employed.

Name of employed individual	Employers Name	Employers Phone Number	Monthly Income
1)			
2)			
3)			
4)			

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5. If unemployed, state for how long the applicant has been unemployed. If receiving unemployment benefits, please send copy of the last 3 pay periods.

_____

_____

Note: If applicant with no job is receiving financial help by a third party (family or friend) it is necessary for the third party (family or friend) to submit a written statement about the financial help being provided to applicant.

6. Do you receive any government assistance? If your answer is yes, please explain.

Name of the person receiving income	Amount received	How often?
1)		
2)		
3)		
4)		

BANK ACCOUNTS CHECKING AND SAVINGS

7. Provide checking and savings bank account statements for the last 3 months.

Data Statement:

8. Are you escaping from the law to avoid persecution for a major felony or to avoid being arrested after a conviction, or for a probation violation? YES ◯ NO ◯ If your answer is yes to any question, please explain:

_____

_____

9. Have you been convicted for a major felony related to drugs (including marijuana) and/or alcohol? YES ◯ NO ◯ If your answer is yes, please explain:

_____

_____

10. Have you completed a drug and or alcohol treatment program certified by the government? YES ◯ NO ◯ If your answer is yes, please explain:

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Employment Verification Form

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Contact Person: Abby Hannah
Email: abbyh@csfsurgery.com

Name and Address of Employer:

_____

_____

_____

_____

Phone Number: _____

Fax: _____

_____
Signature of applicant

Employment Verification Requested for:

Name of Employee: _____ SSN (If known): _____

*****To be completed by an authorized office manager*****

Job Title: _____

Employment begin date: _____ Employment End Date: _____

Current Gross Wages/Salary: _____ Circle one: Hourly Weekly Bi-weekly Monthly Other _____

Average # of regular hours per week: _____ hrs. Number of weeks per year: _____

Commission, bonuses, tips, other: $ _____ Circle one: Hourly Weekly Bi-weekly Monthly Other _____

Additional comments:

_____

_____

Completed By:

Office Manager: _____ Job Title: _____

Signature: _____ Date: _____

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This is your opportunity to tell us in detail about your health problems, why you need help, your economic situation and other information that you consider relevant and important mentioning.

Your Story:

_____

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Your Story (continuation):

Initials _____

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CERTIFICATION

- I understand all questions on this form.
- I understand and agree that all information provided, including information about benefits and income will be verified and that I will have to provide the necessary documentation to verify the given information.
- I understand that my case eligibility will be based on the information given in this application including all additional information if requested by CSF Medical Non-Profit Foundation.
- I understand that my case could be reviewed more than once in order to determine eligibility.
- I also understand that the Board of Directors thoroughly study all cases and there is a possibility my case won't be accepted and be rejected.

I declare that my answers have been truthful. I declare under penalty of perjury, under the laws of the state of California and The United States of America, that the information given in this data statement are true, correct, and complete.

_____	_____	_____
Applicants Full Name	Signature	Date

For exclusive use of CSF Medical Non-Profit Foundation

_____	_____	_____
CSF Counselor	Signature	Date

Amount Approved: $ _____ **Date of Surgery:** _____

_____	_____
Karla Terrazas Director	Approval Date

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CSF Medical Non-Profit Foundation Rules and Regulations

- You have rights and responsibilities when you apply for financial assistance for surgical services with CSF Foundation. Your most important right is to be treated equally regardless of race, skin color, national origin, politics, religion, gender, age, disability, sexual orientation, and or immigration status.
- You can receive assistance with your application or financial documents.
- You will be treated with courtesy, respect, and consideration.
- To apply does not guarantee approval for financial assistance.
- CSF Foundations committee will determine eligibility and amount of financial assistance provided.
- You could qualify for total or partial payment for your surgery according to what the committee approves and advices.
- We will only consider applicants with an established surgical diagnostic which will be evaluated by a CSF physician.
- If the applicant has been approved for CSF Foundation financial assistance, completion of surgery will depend on the assessment of the specialist-surgeon, and/or in some cases the anesthesiologist.
- In case of approval, if the applicant presents serious medical illness, surgery will be considered once those pre-existing conditions are stabilized and suitable for surgery.
- All applicants who live outside Bakersfield, CA must be willing to travel to Bakersfield, CA to receive their evaluation and surgical services if applicable.
- CSF Medical Non-Profit Foundation has the right to use any medical institution to perform the surgery. All approved amounts will be given directly to the institutions. Applicants under no circumstances receive any amount.
- All applicants must participate in an interview either in person or by the phone conducted by a CSF Foundation medical counselor.
- All approved applicants have the responsibility to provide written and/or filmed testimonies in the benefit of CSF Foundation in order to execute marketing campaigns or proof to donors and sponsors.
- All approved funds are available to approved patients for no longer than 3 months from the initial approval date. If for whatever reason the patient does not use the allowed funds within the 3-month period he or she must reapply to CSF Foundation.

Patient Signature: _____ Date: _____