Updated 7-26-21

Ability to Pay Program - Documentation Checklist

The following documentation is required to determine eligibility for participation in the Ability to Pay (ATP) Program. Provisional approval, pending income verification, may be granted for up to 10 business days.

All Applicants
☐ Family Size
☐ Income Verification

Income Verification Documentation:

If employed, provide one or more of the following, as applicable:
☐ Current consecutive paystubs (minimum two)
☐ Copy of most recently filed Federal Income Tax Return
☐ Employer signed statement of itemized earnings[1]
☐ Income Calendar[2]

If unemployed, provide one or more of the following, as applicable:
☐ Current consecutive unemployment check stubs (minimum two)
☐ A letter from the individual who supplies food and shelter to the applicant
☐ Public assistance, including General Assistance and CalFresh
☐ Child/Spousal Support
☐ Bank Statement (if requested for verification)

Retirement/disability income, if applicable:
☐ Social Security award letter
☐ Statement of retirement benefits from the issuing agency(ies)

Non-Residents of Santa Cruz County:
☐ Service Request Affidavit[2]

[1]Statement must include individual's gross earnings and income deductions, frequency of earnings, employer's signature and date signed, and employer's business address and telephone number.
[2]Form will be provided.

Ability to Pay Program - Application

Eligibility for the Ability to Pay (ATP) Program is based on family household size and total family income. The ATP program applies to services provided by HSA's Clinic Services Division, not services or equipment provided by outside medical providers. This form must be completed every 12 months or if your financial situation changes.

Applicant Information	Today's Date:		
First Name:	Middle:	Last:	Other names (AKA):
Home address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Are you eligible for Medi-Cal? ☐ Yes ☐ No ☐ Don't know or unsure	Social Security #	Do you have insurance? (circle one) Yes No	

Name	Date of Birth	Income Sources (compute monthly)		
		Employment Income	Non-employment Income	Retirement/ Disability Income
1. Primary Applicant:				
2. Spouse/Partner:				
3. Dependent Children (Under 21): a. b. c.				
Total [add 1-3 above]				

Attach another application sheet for additional family household members.

Total Family Household Size: _____ Total Monthly Family Household Income: $ _____

I certify under penalty of perjury under the laws of the State of California that I have provided complete and correct income information as shown above. I understand that any misleading or falsified information and/or omissions may disqualify me from the ATP Program. I agree to inform Clinic Services Business Office within 10 business days if there are changes to the information provided on my application.

Applicant's Signature: _____ Date: _____

OFFICE USE ONLY

FPL %: _____ Annual Income Verified: _____

ATP Tier Level: _____ Effective Date: _____

Approved by [print name]: _____ Expiration Date: _____

Ability to Pay Program - Affidavit

Date:_____

Applicant's Name:_____

Applicant's Address: _____

Applicant's Telephone/Cell Phone Numbers: _____

Self-Report of No Income Source

☐ I certify that I do not currently receive ~~an~~ income from any source and will notify Clinic Services Business Office within 10 business days if this changes.

Signature:_____ Date: _____

Non-residency Service Request

☐ I am not a resident of Santa Cruz County; however, I am requesting services from the County of Santa Cruz Health Services Agency for the following reason(s): _____

_____.

Signature:_____ Date: _____