

## SCCA FAMILY ASSISTANCE APPLICATION

The SCCA Family Assistance Fund was established and maintained through generous ongoing donations from individuals and community groups desiring to help families during their treatment in Seattle. Assistance is granted to those patients and families with critical financial needs.

### SCCA Financial Assistance Eligibility Requirements:

1. Patient must be an active patient of the SCCA with multiple monthly appointments.
2. Patient must have a completed Family Assistance Fund Application including back-up documentation.
3. Patient or Family Member must speak with an SCCA Social Worker or Patient Navigator, who has concluded that the patient has applied for & exhausted all other resources.
4. Patient must demonstrate need as verified by the application.

### Additional Eligibility Requirements for Temporary Lodging Assistance:

1. Temporary relocation must be considered medically necessary.
2. Must maintain a primary residence outside the city limits of Seattle.

### SCCA Family Assistance Limits and Conditions:

1. Funding is limited; approval is not guaranteed and/or patients may get less than requested.
2. Funds are designed to cover extraordinary non-medical expenses incurred as a result of treatment (ex. transportation)
3. Funds are not intended to be an income replacement and have a maximum dollar and time limit.

### The Family Assistance Fund does NOT assist with the following expenses:

- Medical Bills
- Pharmacy bills, co-pays, etc.
- Mortgage Payments or 2 bedroom apts.
- Luxury or Recreational vehicle payments
- Skilled Nursing Care
- Reproductive Banking

### Required Documentation

You must provide TWO of the following items:

- Any Proof of income for the last 3 months (i.e. disability award letter, pay stub)
- Bank statements for previous 3 months
- Income tax statement from last year

## APPLICATION CHECK LIST

**Only completed applications will be accepted.** Please check off items when completed. This page is for you to keep.

- Section A – Patient Information
- Section B – Patient Work History
- Section C – Other Income Sources Within Household
- Section D – Share Your Story
- Section E – Financial Worksheet
- Section F – Patient Financial Need
- Section G – Verification
- Section H – Social Work/Patient Navigator Statement
- Required Documentation- Two Items from the list

**SCCA FAMILY ASSISTANCE APPLICATION**  
**CONFIDENTIAL**

**A. PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ U # \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Permanent Address: \_\_\_\_\_

Temporary Address: \_\_\_\_\_

Home: (     ) \_\_\_\_\_ Cell: (     ) \_\_\_\_\_

Date of next SCCA appointment \_\_\_\_\_ Anticipated Length of Treatment: \_\_\_\_\_

Dependants (list names and ages):  
\_\_\_\_\_

If you've temporarily relocated, please list those who will be in Seattle with you:  
\_\_\_\_\_

**B. PATIENT WORK HISTORY**

Has the patient worked in the past year?      YES - Date last worked \_\_\_\_\_      NO

Is the patient taking an approved leave from work:      YES      NO     Paid Leave/Unpaid Leave:      Paid      Unpaid

Occupation/Position: \_\_\_\_\_ Net Monthly Income: \_\_\_\_\_

Employer: \_\_\_\_\_

Are there conditions to your leave from work? If So, Explain:  
\_\_\_\_\_

**C. OTHER INCOME SOURCES WITHIN HOUSEHOLD**

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Is this person currently working?      YES      NO - Date last worked \_\_\_\_\_

Is this person taking an approved leave from work:      YES      NO     Paid Leave/Unpaid Leave:      Paid      Unpaid

Occupation/Position: \_\_\_\_\_ Net Monthly Income: \_\_\_\_\_

Employer: \_\_\_\_\_

Are there conditions to your leave from work? If So, Explain:  
\_\_\_\_\_

**D. SHARE YOUR STORY**

**Are you willing to talk to someone about your cancer experience, which may help raise funds and bring awareness to the need for this program?** Answering "YES" is only an indication of your willingness for us to contact you later- we usually don't contact you until at least a year after treatment. Even then you are not under any obligation to talk to us. Your answer will NOT influence approval for assistance

YES, contact me later

NO, do not contact me at all

**E. FINANCIAL WORKSHEET**

Income Type	Monthly take-home amount	Comments
Employment - patient		
Employment - spouse/partner/sig. Other		
Employment - mother/guardian		
Employment - father/guardian		
Employment – Other (anyone in household)		
Disability payments -patient		
Disability payments –other in household		
Alimony or Child Support		
Pension/annuity		
Other (specify):		
Other (specify):		
<b>TOTAL CURRENT INCOME</b>		

Savings/Assets	Amounts	Comments
Savings Account		
Stock/Bonds		
Gift Donations/inheritance/State Dividends		
Mutual Funds		
IRA/ 401K		
Dividends/Interest Income		
<b>TOTAL CURRENT ASSETS</b>		

Expense Type	Monthly Average Owed	Comments
<i>Permanent housing - mortgage/rent</i>		
<i>Permanent housing - utilities</i>		
<i>Temporary housing - rent</i>		
<i>Temporary housing - utilities</i>		
Phone ( <i>permanent/temporary</i> )		
TV/Cable/Internet ( <i>permanent/temp</i> )		
Food ( <i>average for entire household</i> )		
Gas		
Parking		
Taxi/ Public Transportation		
Vehicle Payments		
Other Loan payments		
COBRA/Health Insurance Premiums		
Auto Insurance		
Child Care		
School Costs		
Other (Specify)		
Other (Specify)		
<b>TOTAL CURRENT EXPENSES</b>		

F. PATIENT FINANCIAL NEED

**PATIENT STATEMENT OF NEED**

Explain to us your financial need (you may use additional paper). You do not need to write a lot –and you are not required to write anything – but your willingness to do so would be very helpful!

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**ASSISTANCE TYPE**

Check the box next to each type of assistance that is the greatest need in your household. You may check more than one item, but you may not get it all.

- FOOD** for patient and/or caregivers
  - For how many people? \_\_\_\_\_
  - Comments: \_\_\_\_\_
  
- GROUND TRANSPORTATION** for patient and/or caregivers
  - Approx. round trip to the SCCA: # of miles \_\_\_\_\_
  - Parking \$ \_\_\_\_\_ per month
  - Comments: \_\_\_\_\_
  
- TEMPORARY LODGING** for patient and/or caregivers
  - Due monthly \$ \_\_\_\_\_
  - Comments: \_\_\_\_\_
  
- INSURANCE PREMIUMS** for the patient
  - Due monthly \$ \_\_\_\_\_
  - Comments: \_\_\_\_\_
  
- OTHER:** \_\_\_\_\_
  - Comments: \_\_\_\_\_

**ASSISTANCE AMOUNT**

From your total monthly expenses, how much are you able to cover?..... \$ \_\_\_\_\_

From your total monthly expenses, how much additional assistance is needed per month? ....\$ \_\_\_\_\_

