Seattle Cancer Care Alliance
Fred Hutch · Seattle Children's · UW Medicine

SCCA FAMILY ASSISTANCE FUND APPLICATION

The SCCA Family Assistance Fund (FAF) was established and is maintained through charitable donations from individuals and community groups desiring to help families during their cancer treatment in Seattle. Assistance is granted to those patients and families with critical financial needs brought about by their treatment.

Eligibility Requirements:

Eligibility can only be considered if **ALL** of the following conditions are met:

1. The patient must be receiving care within the SCCA Inpatient or Outpatient sites of care.
2. FAF can only be granted to eligible patients after they have started treatment at SCCA.
3. All other resources have been identified and acknowledged or have been exhausted.
4. A patient must be receiving **active** and **ongoing** treatment.
5. A patient must have multiple visits/days in a month.
6. A complete application must be submitted.

The patient or family member must speak with an SCCA Social Worker or Patient Navigator, who has concluded that the patient is aware of and is pursuing all available resources.

Active treatment is defined as an SCCA patient with a diagnosis requiring a regular course of treatment as outlined in a plan of care determined by the medical team.

Ongoing treatment may include, but is not limited to, the following: surgery, chemotherapy, immunotherapy, radiation, procedure, exam with a provider or infusion.

Limits and Conditions:

- Approval is not guaranteed, and any amount granted may be less than requested.
- Funds are designed to cover extraordinary, non-medical expenses which have been incurred as a result of treatment.
- Funds are not intended to be an income replacement.
- The SCCA has the right to re-evaluate and amend determination of financial assistance at any time.
- The FAF does not assist with the following expenses: medical bills, pharmacy bills, insurance premiums, mortgage payments, apartment rental support for any unit larger than a one-bedroom, luxury or recreational vehicle payments, skilled nursing facility care, caregiving services, or fertility preservation.

Required Documentation:

- Patient must provide the following documents:

☐ Proof of household income for the last three months (example: pay stubs or disability award letter)

☐ Bank statements for all household accounts within the last three months. If no bank accounts, please describe how you pay your bills.

☐ **Please note**: You may be asked for documentation about your retirement/investments if you indicate that you are unable to draw from them.

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A. PATIENT INFORMATION

Patient Name: ___________________________________ U Number: _______________ Date of Birth: _______________

Permanent Address: ____

Temporary Address: ____

Home Phone: ______________________ Mobile Phone: _____________________ E-mail: __________________________

Date of next SCCA appointment: ____________________ Anticipated Length of Treatment: ________________________

Site of care: ☐ South Lake Union ☐ Issaquah ☐ Peninsula ☐ Northwest Hospital ☐ Evergreen

Dependents (list names and age): ____

If the patient has temporary relocated, please list those who will be in Seattle with you:

____

B. EMPLOYMENT AND INSURANCE

Have you worked in the past year? ☐ Yes ☐ No Date last worked: _________________________________

Employer: _______________________________________ Net Monthly Income: ______________________________

Are you taking an approved leave from work? ☐ Yes ☐ No ☐ Paid ☐ Unpaid Leave

Does your employer offer: ☐ Short-term disability insurance ☐ Long-term disability insurance

☐ Donated leave ☐ Haven't inquired yet

If you are not working, were there conditions to your leave from work? If so, please explain:

____

Primary Insurance Provider: _________________________ Secondary Insurance Provider: _________________________

Percent of insurance coverage: ____________% Supplemental Insurance (i.e. Aflac): _______________________________

Does your insurance have a travel or lodging benefit: ☐ No ☐ Yes Amount: $__________________________

C. OTHER HOUSEHOLD INCOME SOURCES

Caregiver/Family Member Name: ____________________________________ Relation to Patient: ____________________

Employer: ____ Net Monthly Income: _________________________________

For Staff Use Only	
Date completed app received:	**Plan of Care**:
First SCCA Appt Date:	**Team/Clinic**:
Primary Diagnosis:	

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D. FINANCIAL WORKSHEET

Income Type	Monthly Amount	Patient Comments	Staff Comments
Employment – Patient			
Employment – Spouse/Partner			
Employment – Other in household			
Social Security – Patient			
Social Security – Other in household			
Food stamps			
Alimony or Child Support			
Pension/Annuity			
Other (specify)			

Savings/Assets	Amounts	Patient Comments	Staff Comments
Checking and Savings Account			
Stock/Bonds/Mutual Funds			
Donations/Fundraising/Dividends			
IRA/401K/Retirement/Pension			

Type of Monthly Expense	Monthly Amount	Patient Comments	Staff Comments
Permanent Housing – Mortgage/Rent			
Permanent Housing – Utilities			
Permanent Housing – TV/Cable/Internet			
Temporary Housing – Mortgage/Rent			
Temporary Housing – Utilities			
Temporary Housing – TV/Cable/Internet			
Phone (Home/Mobile)			
Food for Household			
Gas and Parking			
Taxi/Other Transportation			
Vehicle Payment			
Debit/Credit Card/Loans*			
Health Insurance Premium			
Co-pays/Deductibles			
Vehicle Insurance Premium			
Child Care/School Costs/Support			
Other (specify):			

If a credit card is used for food, gas etc. please include expense in appropriate expense type and subtract from the debit/credit card amount.

For Staff Use Only	
Total Amount of Current Assets	
Total Amount of Current Income	
Total Monthly Expenses	
= (+/-) Current Available	

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E. STATEMENT OF FINANCIAL NEED

Explain to us your financial need. Please include any information you feel that we should know that has not been already captured in this application (you may use additional paper).

____

____

____

F. TYPES OF ASSISTANCE REQUESTED

Check the box next to each type of assistance that you believe is the greatest in need in your household. You may check more than one item, but please keep in mind that the amount granted may be less than requested.

☐ Food for how many people? ______________________ Amount requested? $ ____________________

☐ Ground Transportation for the patient and/or caregiver
Approximate number of miles from home to SCCA: ___________ How often? ___________

Amount requested? $ _____________________

Please note: The following would only be considered if an insurance lodging benefit is unavailable or inaccessible.

☐ Temporary lodging for patient and caregiver Monthly amount due: $ _________________

Have you previously received assistance from the SCCA Family Assistance Fund before? ☐ Yes ☐ No

G. VERIFICATION

To the best of my knowledge:

- This information provided on the form is accurate.
- I give my consent for further verification of this information as necessary.
- I understand that if the information is determined to be false, misleading, or incomplete, I will be denied assistance.
- I have read and understood the FAF eligibility requirements. I am responsible for updating the SCCA if my financial status changes.
- I have carefully examined my financial situation and have begun to liquefy any savings or luxury items and adjusted my household spending to aid with my expenses.

Signature: ____ Date: ____________________________

Printed Name: ____ Relationship to Patient: ____________________________

Please give the completed application to your Social Worker or Patient Navigator. You can also return this to the Patient and Family Services office located on the 1st floor of the main SCCA clinic. If you are applying in advance of your arrival, please send the completed application and documentation to housing@seattlecca.org or fax to 206-606-1077.

Last updated: 05/09/2019

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SOCIAL WORKER/PATIENT NAVIGATOR STATEMENT

(Completed by SCCA Social Worker or Patient Navigator)

Patient Name: ______________________________________ U Number: ____________________ Date: _____________

Team/Clinic: _____________________________ Social Worker/Patient Navigator: _______________________________

- Describe any circumstances not apparent or previously described in the application.

  ____

  ____

  ____

- Describe the type and amount of financial assistance that you believe would help the patient the most based on your assessment.

  ____

  ____

  ____

  Briefly outline the treatment plan and how long the treatment is anticipated to last and how long would the patient and caregiver need to relocate (if applicable)?

  ____

  ____

- Please identify any resources that the patient is currently pursuing or funds that the patient has been granted including the amounts.

  ____

  ____

  ____

  If application is missing required documents – Why?

  ____

  ____

Have you discussed:

☐ Loan deferral programs
☐ Disability/GAP Insurance for vehicles
☐ Donated leave from employer
☐ Life insurance buy-back program
☐ Social Security for children/dependents that are minors
☐ Cancel/Hold utility bills
☐ Travel/lodging benefit from insurance

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