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.

Last updated: 05/09/2019
# SCCA FAMILY ASSISTANCE FUND APPLICATION

## A. PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Patient Name: ___________________________</th>
<th>U Number: ___________________________</th>
<th>Date of Birth: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Address: _________________________________________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporary Address: _________________________________________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Phone: _____________________</td>
<td>Mobile Phone: _____________________</td>
<td>E-mail: _________________________</td>
</tr>
<tr>
<td>Date of next SCCA appointment: ____________________</td>
<td>Anticipated Length of Treatment: ______________________</td>
<td></td>
</tr>
</tbody>
</table>

- **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: _______________________________

---

<table>
<thead>
<tr>
<th>For Staff Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date completed app received:</td>
</tr>
<tr>
<td>First SCCA Appt Date:</td>
</tr>
<tr>
<td>Primary Diagnosis:</td>
</tr>
</tbody>
</table>

Last updated: 05/09/2019
# D. FINANCIAL WORKSHEET

## Income Type

<table>
<thead>
<tr>
<th>Income Type</th>
<th>Monthly Amount</th>
<th>Patient Comments</th>
<th>Staff Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment – Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment – Spouse/Partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment – Other in household</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security – Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security – Other in household</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food stamps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alimony or Child Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pension/Annuity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Savings/Assets

<table>
<thead>
<tr>
<th>Savings/Assets</th>
<th>Amounts</th>
<th>Patient Comments</th>
<th>Staff Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checking and Savings Account</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stock/Bonds/Mutual Funds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donations/Fundraising/Dividends</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IRA/401K/Retirement/Pension</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Type of Monthly Expense

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

*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              |         |                  |               |
SCCA FAMILY ASSISTANCE FUND APPLICATION

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
SCCA FAMILY ASSISTANCE FUND APPLICATION

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
☐ Social Security for children/dependents that are minors
☐ Donated leave from employer
☐ Cancel/Hold utility bills
☐ Life insurance buy-back program
☐ Travel/lodging benefit from insurance

Last updated: 05/09/2019