

## Financial Assistance/Charity Care Application Form Instructions

This is an application for financial assistance (also known as charity care) at Seattle Cancer Care Alliance (SCCA).

**Washington State requires all hospitals to provide financial assistance** to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. For more information, contact our Revenue Cycle Customer Service Department at (206) 606-6226 or toll free at (800) 304-1763, Monday through Friday, 7:30 a.m. – 4 p.m. (Pacific Time).

**What does financial assistance cover?** The hospital financial assistance covers appropriate hospital-based services provided by SCCA depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

**If you have questions or need help completing this application:** Please call SCCA's Revenue Cycle Customer Support Department at (206) 288-6226 or toll free at (800) 304-1763. You may obtain help for any reason, including disability and language assistance.

### **In order for your application to be processed, you must:**

- Provide us information about your family**  
Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- Provide us information about your family's gross monthly income (income before taxes and deductions)**
- Provide documentation for family income and declare assets**
- Attach additional information if needed**
- Sign and date the form**

**Note:** You do not have to provide a Social Security number to apply for financial assistance. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

### **Mail or fax completed application with all documentation to:**

SEATTLE CANCER CARE ALLIANCE  
PATIENT FINANCIAL SERVICES  
PO Box 19023  
MS LG300  
Seattle, WA 98109  
Fax: (206) 606-6299

Be sure to keep a copy for yourself.

### **To submit your completed application in person to a financial counselor or to:**

SEATTLE CANCER CARE ALLIANCE  
PATIENT REGISTRATION DEPARTMENT  
825 Eastlake Ave E  
Seattle, WA 98109  
Phone: (206) 606-6226  
Monday through Friday: 7 a.m. to 5 p.m.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

**We want to help. Please submit your application promptly!**

## Financial Assistance /Charity Care Application Form

*Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.*

### SCREENING INFORMATION

Do you need an interpreter? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <i>If Yes, list preferred language:</i>
Has the patient applied for Medicaid? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <i>May be required to apply before being considered for financial assistance</i>
Does the patient receive state public services such as TANF, Basic Food, or WIC? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Is the patient currently homeless? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Is the patient's medical care need related to a car accident or work injury? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

### PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

### PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name	Patient last name
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (may specify _____)	Birth Date	Patient Social Security Number* <small>*see note on page 1 regarding Social Security Number</small>
Person Responsible for Paying Bill	Relationship to Patient	Birth Date Social Security Number* <small>*see note on page 1 regarding Social Security Number</small>
Employment status of person responsible for paying bill <input type="checkbox"/> <b>Employed</b> (date of hire: _____) <input type="checkbox"/> <b>Unemployed</b> (how long unemployed: _____) <input type="checkbox"/> <b>Self-Employed</b> <input type="checkbox"/> <b>Student</b> <input type="checkbox"/> <b>Disabled</b> <input type="checkbox"/> <b>Retired</b> <input type="checkbox"/> <b>Other</b> ( _____ )		
Mailing Address  _____ _____ City                                  State                                  Zip Code _____ Country	Permanent Address (if different than the Mailing Address)  _____ _____ City                                  State                                  Zip Code _____ Country	
Contact Information  Email Address: _____  Main contact number(s): <b>Home</b> ( ) _____ <b>Mobile</b> ( ) _____ <b>Work</b> ( ) _____		

**Residency Information**

*Financial Assistance is limited to residents of Washington State as defined by SCCA policy, but nonresidents may qualify for other programs or financial support.*

How long have you lived in Washington State? \_\_\_\_\_

How long do you plan to live in Washington State? \_\_\_\_\_

If you have lived in WA for less than 1 year, why did you come to the state?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY INFORMATION**

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

**FAMILY SIZE** \_\_\_\_\_

*Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

**All adult family members' income must be disclosed. Sources of income include, for example:**

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI
- Child/spousal support - Work study programs (students) - Pension - Retirement account distributions
- Other (*please explain* \_\_\_\_\_)

**INCOME INFORMATION**

**REMEMBER:** *You must include proof of income with your application.*

**You must provide income for family members listed above. Income verification is required to determine financial assistance.**

**All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.**

**Examples of proof of income include:**

- A "W-2" withholding statement; or
- Current pay stubs (*3 months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

### EXPENSE INFORMATION

*We use this information to get a more complete picture of your financial situation.*

**Monthly Household Expenses:**

Rent/mortgage	\$ _____	Medical expenses	\$ _____
Insurance Premiums	\$ _____	Utilities	\$ _____
Other Debt/Expenses	\$ _____ <i>(child support, loans, medications, other)</i>		

### ASSET INFORMATION

*This information may be used if your income is above 300% of the Federal Poverty Guidelines.*

<p>Current checking account balance \$ _____</p> <p>Current savings account balance \$ _____</p>	<p>Does your family have these other assets? <b>Please check all that apply and provide supporting documentation</b></p> <p><input type="checkbox"/> Stocks   <input type="checkbox"/> Bonds   <input type="checkbox"/> 401K   <input type="checkbox"/> Health Savings Account(s)   <input type="checkbox"/> Trust(s)</p> <p><input type="checkbox"/> Property (excluding primary residence)   <input type="checkbox"/> Own a business</p>
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### ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

### PATIENT AGREEMENT

I understand that SCCA may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

\_\_\_\_\_  
Signature of Person Applying

\_\_\_\_\_  
Date