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

SCCA FAMILY ASSISTANCE APPLICATION

The SCCA Family Assistance Fund 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:

1. Patient must be an active patient of the SCCA with multiple monthly appointments.
2. Patient must complete a 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 is aware of all other resources.
4. Patient must demonstrate need as verified by the application.
5. Patient must demonstrate that s/he has made efforts to adjust household spending in order to aid with expenses, and has begun the process of liquefying savings, luxury items, and pensions/investments.

Temporary Lodging Assistance Requirements:

1. Temporary relocation must be determined to be medically necessary by the provider.
2. Patient must maintain a primary residence outside the city limits of Seattle.
3. Lodging for caregivers is included *only* while patient is in the hospital & not using the room, and is limited to seven nights (based on & exceeding DSHS lodging benefits).

Limits and Conditions:

1. Funding is limited; approval is not guaranteed; amount awarded may be less than requested.
2. Funds are designed to cover extraordinary, non-medical expenses which have been incurred as a result of treatment (example: transportation).
3. Funds are not intended to be an income replacement and have maximum dollar and time limits.
4. 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 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
- You may be asked for documentation about your retirement/investments if you indicate that you are unable to draw from them.

SCCA FAMILY ASSISTANCE APPLICATION

CONFIDENTIAL

1st SCCA Appt. Date:___________
Diagnosis:___________________
Treatment:__________________
Team or Clinic:________________

A. PATIENT INFORMATION

Patient Name: _________________________________ U # _______________________ D.O.B: _____/_____/_____

Permanent Address: ____

Temporary Address: ____

Home: (   ) ___________________________ Cell: (   ) _____________________________

Email address: ____

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

Dependents (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

Net monthly income: _____________________________ Employer: ____

If not working, were there conditions to your leave from work? If so, please 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

Net monthly income: _____________________________ Employer: ____

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

____

D. INSURANCE

Primary Insurance Provider: _____________________________ Secondary Insurance Provider: ___________________________

Percent of Insurance Coverage: ___________________%
Does your insurance have a travel or lodging benefit: [ ] NO [ ] YES - Amount_________________________________

E. FINANCIAL WORKSHEET

Income Type	Monthly take-home amount	Comments
Employment - patient		
Employment - spouse/partner/sig. other		
Employment – parents/guardian		
Employment – other in household		
Social Security Disability (SSD) -patient		
Social Security Disability -other in household		
Food Stamps		
Alimony or Child Support		
Pension/Annuity		
Other (specify):		
TOTAL CURRENT INCOME =		

Savings/Assets	Amounts	Comments
Checking & Savings Account		
If no account, how do you pay your bills		
Stock/Bonds/Mutual Funds		
Donations/Inheritance/State Dividends/ Fundraising		
IRA/ 401K/Retirement		
Dividends/Interest Income		
TOTAL CURRENT ASSETS=		

Expense Type	Monthly Average Owed	Comments
Permanent housing - Mortgage/Rent		
Permanent housing - Utilities		
Permanent housing – TV/Cable/Internet		
Temporary housing - Rent		
Temporary housing - Utilities		
Temporary housing – TV/Cable/Internet		
Phone		
Food (average for entire household)		
Gas & Parking		
Taxi/ Public Transportation		
Vehicle Payments		
Other Loan payments		
COBRA/Health Insurance Premiums		
Co-pays/Deductibles		
Auto Insurance		
Child Care		
School Costs		
Other (Specify)		
TOTAL MONTHLY EXPENSES=		
- (Minus) CURRENT INCOME=		
CURRENT AVAILABLE $ =		

F. PATIENT FINANCIAL NEED

PATIENT STATEMENT OF NEED

Explain to us your financial need. Please include any information you feel we should know that has not been captured in this application (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? ….$___________

G. VERIFICATION

1. To the best of my knowledge this information provided on this form is accurate......... [ ] Yes [ ] No
2. I give my consent for further verification of this information as necessary. .... [ ] Yes [ ] No
3. I understand that if the information is determined to be false, misleading or, incomplete, I will be denied assistance.. [ ] Yes [ ] No
4. I have read and understood the Family Assistance Fund eligibility requirements........... [ ] Yes [ ] No
5. I have carefully examined my financial situation and have begun to liquefy (turn to cash) any savings or luxury items and adjusted my household spending to aid with my expenses.. [ ] Yes [ ] No
6. I have investigated or am in the process of applying for assistance with the below agencies and can provide copies of all acceptances/denials, if requested...[ ] Yes [ ] No

❒ State Assistance, Dept of Social and Health Services for medical coverage, cash, food stamps, etc.

Approved Denied In Process N/A

❒ Social Security/Disability

Approved Denied In Process N/A

❒ Other (please list)

____

Approved Denied In Process N/A

Signature____Date__________________________

Print Name______________________________________ Relation to PT __________________________

Please give completed application to your Social Worker, Patient Navigator or the Patient Family Services office on the 1st Floor. If you are applying in advance of your arrival, send completed application and documentation to: housing@seattlecca.org, or FAX: 206-288-1077

FOR OFFICE USE ONLY	Pt Arrival/Tx Date:
Support Recommended:	Funding Support Approved? Y/N
Monthly Gross Income $	Patient Participation $
Useable Assets $	Weekly $
Monthly Home Expenses $	Monthly $ /
Monthly Seattle Expenses $	Beginning:
Income Available	Date Notified Patient/Family:

App: p/u: ____________	HC received: ___________
Pt. turned in: __________	Decision: _______________
PFS logged: ___________	$ Distributed: ___________

This Page For Office Use Only:

SOCIAL WORKER/ PATIENT NAVIGATOR STATEMENT

(Completed by SCCA Social Worker or Patient Navigator)

Patient Name: ________________________________U Number: ____________________

Team/Clinic: ______________________Social Worker or Navigator: __________________________

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

____

____

2. Describe the type and amount of financial assistance that would help the patient the most based upon your assessment.

____

____

3. Briefly outline treatment plan; what plan, how long need to relocate here? How long tx to last?

____

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Please identify any funds patient has or is currently receiving:

- ❑ Leukemia & Lymphoma Society $______
- ❑ LLS Co-Pay $_____
- ❑ Lymphoma Res Foundation $______
- ❑ Ntl Marrow Donor $_____
- ❑ Bone Marrow Foundation $______
- ❑ Cancer Care $________
- ❑ Cancer Lifeline $_______
- ❑ Life Beyond CA $_______
- ❑ Team Continuum $________
- ❑ 21st Century Care _______
- ❑ Rick Pankow Foundation $ _________
- ❑ Lazarex Foundation (Clin Trial)$________
- ❑ Komen $___________
- ❑ SCCA Women's Center Cards $________
- ❑ Kristy Lasch Miracle Foundation $_____
- ❑ NW Sarcoma Foundation $___________
- ❑ Colon CA Alliance-Blue Note Fund $____
- ❑ Pediatric: NCCS $_____
- ❑ Candlelighters $______
- ❑ Kyle Chavat Found. (18-25) $ ______
- ❑ JensThank You Alliance (15-39) $_____
- ❑ The Sam Fund (17-35) $______
- ❑ Brenda Mehling CA Fund (18-40) $_____
- ❑ We Believe Found. (15-29) $_______
- ❑ FundRaising $_______
- ❑ Food Stamps $_______
- ❑ DSHS Cash Assist $______
- ❑ DSHS Gas, Parking Reimb $______
- ❑ METRO Access
- ❑ Senior Services
- ❑ Other _______________________

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