Seneca Healthcare District Charity Care Application

Instructions:

1. Prior to completing an application for Charity Care, the patient is referred to Seneca Healthcare District's patient financial specialist (PFS) for application for insurance through Covered California.

2. **The following documents are required to be submitted with your completed SHD Charity Care Application (copies only, originals will not be returned):**
    - Patient must apply to Covered California and/or Medi-Cal. Eligibility or denial for insurance coverage must be presented to SHD within 30 days of receipt.
    - Copies of 3 (three) most recent pay stubs from all employers
        - If unemployed, a copy of unemployment benefits award letter or pay stub within the last 30 days
    - Copy of most recent income tax return
    - Copy of most recent bank statement(s)
    - Copy of most recent rent/mortgage receipt
    - Copy of most recent utility bills

3. Return completed application to either:

    Seneca Healthcare District
    P.O. Box 1460
    Chester, CA 96020
    Attn: Finance Department

    Seneca Healthcare District
    C/O: HRG
    12610 E. Mirabeau Pkwy., Suite 900
    Spokane Valley, WA 99216
    Attn: CBO Department Supervisor

    Or it may be delivered in person at Seneca Healthcare District, 199 Reynolds Road, Chester, CA

4. SHD will complete the remainder of the application, including a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history, and notify the patient of the determination in writing within 90 days of receipt of a completed application.

5. If you have questions or need assistance in completing this application, please contact our Patient Accounts Department at **866-567-8936** or the onsite Patient Financial Specialist at **530-259-3591.**

Seneca Healthcare District Charity Care Application

In order to be considered for Seneca Healthcare District's Charity Care Plan, the information below must be completed and returned to our office with all required documentation. Incomplete applications will not be considered.

PATIENT INFORMATION

Date of Request: _____ Social Security Number: _____

Patient Name: _____ Birthdate: _____

Telephone Number: _____

Address: _____ (street)

_____ (city, state, zip code)

If Minor; Guardian Name: _____ Guardian Social Security _____

Employer: _____ Last Day Worked: _____

Do you have? ❒Medi-Cal ❒Medicare ❒Other Insurance ❒Uninsured

If uninsured, have you applied for Medi-Cal/Covered California? ❒ Yes ❒ No

FAMILY INFORMATION

Spouse's Name: _____ Spouse's SSN: _____

Spouse's Employer: _____ Spouse's Birthdate: _____

List all dependents that you support below:

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ASSET INFORMATION

Bank Name: _____ Account Number: _____ Balance: $_____

Bank Name: _____ Account Number: _____ Balance: $_____

Bank Name: _____ Account Number: _____ Balance: $_____

Other Assets: _____

Application Continued:

INCOME INFORMATION

Earned Income (If patient is a minor list parent(s)/guardian(s) income)

Patient's Gross Income: $_____ *(select one)* ❒Monthly ❒Bi-Weekly ❒Weekly

Spouse's Gross Income: $_____ *(select one)* ❒Monthly ❒Bi-Weekly ❒Weekly

Other Income

Unemployment: $_____ *(select one)* ❒Monthly ❒Annually

Social Security: $_____ *(select one)* ❒Monthly ❒Annually

Dividends/Annuities: $_____ *(select one)* ❒Monthly ❒Annually

Rental Property: $_____ *(select one)* ❒Monthly ❒Annually

Other (explain): $_____ *(select one)* ❒Monthly ❒Annually

Total Monthly Income: $_____ **Total Annual Income:** $_____

(Total of Gross Income, Spouse Gross Income, and Other Income)

EXPENSES INFORMATION

I am a *(select one)*: ❒Renter ❒Homeowner _____years Monthly Payment: $_____

Do you own property other than your primary residence? ❒Yes ❒No Monthly Payment: $_____

Auto payment: $_____/mo Year/Make/Model: _____

Auto payment: $_____/mo Year/Make/Model: _____

Credit Card: Balance $_____ Limit $_____ Monthly Payment $_____

Credit Card: Balance $_____ Limit $_____ Monthly Payment $_____

Monthly Utility Bills: $_____ Average Monthly Food Bill: $_____

Are you current on all above payments? ❒Yes ❒No

(Please attach additional sheets if necessary to include additional credit/personal loan/medical obligations)

Total Monthly Expenses: $_____

If your monthly expenses exceed your monthly income, please describe how you are meeting your expenses

_____

_____

_____

_____

Patient Disclosure Report:

Account Number(s): _____

The purpose of this information request is to determine your ability to pay for services at Seneca Healthcare District or your possible eligibility for our Charity Care Policy. This information is **not** an application for Medi-Cal, Covered California, or any County assistance program. Seneca Healthcare District's patient financial specialist will provide you a copy of these applications upon request. If you have been denied by Medi-Cal, Covered California, or County Medical Financial Assistance, submit a copy of the denial with this form.

I_____(print name) certify the foregoing information to be true and correct. I agree and acknowledge that Seneca Healthcare District has provided me with the option to apply for health insurance under Medicare, Medi-Cal, California Health Benefit Exchange, Healthy Families Program, California Children's Services, Covered California, and/or any other applicable State or County funded health coverage. I understand Seneca Healthcare District reserves the right to verify all information supplied, including a credit check. I agree to notify the Business Office of any change in my financial information within 10 (ten) days of the change.

I UNDERSTAND THAT UNTIL CHARITY CARE HAS BEEN GRANTED, I AM STILL RESPONSIBLE FOR THE FULL AMOUNT OF MY CHARGES AT SENECA HEALTHCARE DISTRICT.

If you have any questions, please call the Seneca Healthcare District Patient Financial Specialist at 530-259-3591 or 866-567-8936.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Signature of Spouse Date

_____ _____

Seneca Healthcare District Representative Date

Seneca Healthcare District Charity Care Application

Financial Assessment Worksheet:
***** For Office Use Only *****

Patient Name: _____

Account:	_____	D.O.S:	_____	Total Charges:	$_____	Balance:	$_____
Account:	_____	D.O.S:	_____	Total Charges:	$_____	Balance:	$_____
Account:	_____	D.O.S:	_____	Total Charges:	$_____	Balance:	$_____
Account:	_____	D.O.S:	_____	Total Charges:	$_____	Balance:	$_____
Account:	_____	D.O.S:	_____	Total Charges:	$_____	Balance:	$_____

Date and initial upon receipt of the following documentation:
_____ Covered California/Medi-Cal eligibility or denial
_____ Copies of 3 (three) most recent pay stubs from all employers
_____ If unemployed, copy of unemployment benefits award letter or pay stub within the last 30 days
_____ Copy of most recent income tax return
_____ Copy of most recent bank statement(s)
_____ Copy of most recent rent/mortgage receipt
_____ Copy of most recent utility bills

If all documentation was not received with the application or additional information was requested, date and initial the 3 attempts to contact the patient:
_____ 1st attempt
_____ 2nd attempt
_____ 3rd attempt

Notes:
_____
_____
_____
_____
_____

Financial Assessment Worksheet Continued:
***** For Office Use Only *****

Summary

Family Size: _____
Gross Annual Family Income: $_____ (A)
Less Federal Poverty Guideline: $_____ (B) [@ 150% for Family Size]
Adjusted Gross Annual Family Income: $_____ (C)
Cost Share Scale Percentage C÷B: _____%
Percentage Discount Applicable: _____%

Cost Share Scale

Percentage of Adjusted Gross Annual Income to Federal Poverty Guidelines	Percentage Discount for Charity Care
Less than or equal to zero (≤ 0%)	One hundred percent (100%)
One to thirty-three (1% - 33%)	Seventy-five percent (75%)
Thirty-four to sixty-six (34% - 66%)	Fifty percent (50%)
Sixty-seven to one hundred (67% - 100%)	Twenty-five percent (25%)
Greater than one hundred (> 100%)	Zero percent (0%)

Worksheet Prepared By:

_____ _____ _____
Signature *Printed Name* *Date*

APPROVAL/DENIAL

Approved: ❒ Denied: ❒ Reason _____

Charity Care Amount Approved: $_____

Accounts to apply charity care write off to:

Account: _____ Amount: $_____ Date of write off: _____ Initials _____
Account: _____ Amount: $_____ Date of write off: _____ Initials _____
Account: _____ Amount: $_____ Date of write off: _____ Initials _____
Account: _____ Amount: $_____ Date of write off: _____ Initials _____
Account: _____ Amount: $_____ Date of write off: _____ Initials _____

If total amount of charity care approved ≤ $5,000, approval required by Director of Finance
If total amount of charity care approved > $5,000, approval required by CEO

_____ _____ _____
Signature *Printed Name* *Date*