Seneca Healthcare District Charity Care Application

Instructions:

1. **The following documents are required to be submitted with your completed Charity Care Application (copies only, originals will not be returned):**
    - 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

2. Return completed application to:

Seneca Healthcare District
P.O. Box 737
Chester, CA 96020
Attn: Finance Department

Or it may be delivered in person at Seneca Healthcare District, 199 Reynolds Road, Chester, CA 96020

3. 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 45 days of receipt of a completed application.

4. If you have questions or need assistance in completing this application, please contact our outsourced Business Office at (**844) 951-7275.**

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PATIENT INFORMATION

Patient Name: _____
Telephone _____
Address: _____
_____
If Minor; Guardian Name: _____

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

FAMILY INFORMATION

List all dependents that you support below:

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

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Application Continued:

INCOME INFORMATION

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

Patient's Gross Income: $_____

Spouse's Gross Income: $_____

Other Income

Unemployment: $_____

Social Security: $_____

Dividends/Annuities: $_____

Rental Property: $_____

Other (explain): $_____

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

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

EXPENSES INFORMATION

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: $_____

Monthly Utility Bills: $_____

Monthly Utility Bills: $_____

Monthly Utility Bills: $_____

Average Monthly Food Bill: $_____

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

_____

SENECA
HEALTHCARE DISTRICT

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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. 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 understand Seneca Healthcare District reserves the right to verify all information supplied. I agree to notify the outsourced Billing 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 Seneca Healthcare District's outsourced Billing Office (844) 951-7275.

_____ _____

Signature of Patient/Responsible Party Date

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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:

_____ 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

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 *****

<u>Summary</u>

Family Size: _____
Gross Annual Family Income: $_____ (A)

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Federal Poverty Guideline: $_____ (B)
Percent of FPL _____% A/B
Percentage Discount Applicable: _____%

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 ≤ $500, approval required by Patient Financial Counselor
If total amount of charity care approved > $500, approval required by CFO

_____ _____ _____
Signature *Printed Name* *Date*