Seneca Healthcare District Financial Assistance Application

Instructions:

The following documents are required to be submitted with your completed Financial Assistance Application (copies only, originals will not be returned)

- Copy of recent income tax return or
- Copies of 3 (three) recent pay stubs from all employers
    - If unemployed, a copy of unemployment benefits award letter or pay stub within the last 30 days

1. Copies of recent tax returns (tax returns which document a patient's income for the year in which the patient was first billed or 12-months prior to when the patient was first billed) or
2. Recent paystubs (paystubs within a 6-month period before or after the patient is first billed by the hospital, or in the case of preservice, when the application is submitted)
3. Return completed application to:

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

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

4. SHD will complete the Financial Assessment Worksheet, 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.

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

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PATIENT INFORMATION

Patient Name: _____

Telephone Number: _____

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 Annual Income:** $_____

(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)

_____

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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 Financial Assistance Program. 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 letter 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 FINANCIAL ASSISTANCE 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 contracted Billing Office (844) 951-7275.

_____ _____

Signature of Patient/Responsible Party Date