



## 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)

- 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
1. Copies of most 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 with in 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**.



# Seneca Healthcare District Financial Assistance Application

## 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



# Seneca Healthcare District Financial Assistance Application

## 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 Annual Income:** \$ \_\_\_\_\_

**Total Monthly 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: \$ \_\_\_\_\_

Average Monthly Food Bill: \$ \_\_\_\_\_

Monthly Utility Bills: \$ \_\_\_\_\_

Monthly Utility Bills: \$ \_\_\_\_\_

Monthly Utility Bills: \$ \_\_\_\_\_

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

\_\_\_\_\_



## Seneca Healthcare District Financial Assistance Application

### 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



# Seneca Healthcare District Financial Assistance Application