SENECA
HEALTHCARE DISTRICT

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):**
    - 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

2. Return completed application to either:

    Seneca Healthcare District
    P.O. Box 1460
    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 Business Office at **855.896.6853.**

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PATIENT INFORMATION

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

Do you have? ❒Medi-Cal ❒Medicare ❒Other Insurance ❒Uninsured
If uninsured, have you applied for Medi-Cal/Covered California? ❒ Yes ❒ No

FAMILY INFORMATION

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: _____

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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: $_____ Average Monthly Food

Monthly Utility Bills: $_____

Monthly Utility Bills: $_____

Monthly Utility Bills:$_____

(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 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 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 Seneca Healthcare District's Business Office 855-896-6853.

_____ _____

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:
_____ 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:
_____
_____
_____
_____
_____

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

Summary

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