



Patient Assistance Application

For Fee Determination/Patient Assistance | Please call (805) 681-1760 with any questions

CONFIDENTIAL • PLEASE PRINT CLEARLY

Through the generous contributions of people in our community, the Ridley-Tree Cancer Center/Sansum Clinic is able to provide the highest level of care for all who need it, regardless of their ability to pay. Thank you for your thorough completion of this application so that we may determine how best to support you.

Ridley-Tree Cancer Center Sansum Clinic

Applicant Information

FIRST NAME	MIDDLE INITIAL	LAST NAME	SOCIAL SECURITY NUMBER	
MARITAL STATUS	DATE OF BIRTH	MALE / FEMALE		
CURRENT ADDRESS				
STREET	CITY	STATE	ZIP	DATE FROM / TO
PRIOR ADDRESS(ES) FOR PAST YEAR (IF APPLICABLE)				
STREET	CITY	STATE	ZIP	DATE FROM / TO
STREET	CITY	STATE	ZIP	DATE FROM / TO
HOME PHONE	CELL PHONE	EMAIL ADDRESS		
EMPLOYMENT STATUS	<input type="checkbox"/> EMPLOYED	<input type="checkbox"/> UNEMPLOYED	<input type="checkbox"/> RETIRED	<input type="checkbox"/> DISABLED
OCCUPATION	EMPLOYER	EMPLOYER'S PHONE		
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)				
STREET	CITY	STATE	ZIP	
HOW DID YOU FIRST HEAR ABOUT RIDLEY-TREE CANCER CENTER/SANSUM CLINIC'S PATIENT ASSISTANCE PROGRAM?				

Spouse & Family Information

SPOUSE INFORMATION (IF APPLICABLE)

FIRST NAME	MIDDLE INITIAL	LAST NAME	SOCIAL SECURITY NUMBER	
STREET	CITY	STATE	ZIP	
HOME PHONE	CELL PHONE	EMAIL ADDRESS		
EMPLOYMENT STATUS	<input type="checkbox"/> EMPLOYED	<input type="checkbox"/> UNEMPLOYED	<input type="checkbox"/> RETIRED	<input type="checkbox"/> DISABLED
OCCUPATION	EMPLOYER	EMPLOYER'S PHONE		

FAMILY INFORMATION (IF APPLICABLE) PLEASE INCLUDE INFORMATION FOR ALL WHO LIVE IN YOUR HOUSEHOLD. PLEASE PLACE AN "X" IN COLUMN D IF INDIVIDUAL IS A DEPENDENT.

NAME	AGE	RELATIONSHIP	D	NAME	AGE	RELATIONSHIP	D



Insurance Information

I HAVE NO INSURANCE COVERAGE, INCLUDING MEDICAL OR MEDICARE

PLEASE LIST ANY OTHER SUPPLEMENTAL POLICIES YOU CARRY WHICH PAY FOR MEDICAL SERVICES (SUCH AS AFLAC, CANCER POLICIES, PRIVATE POLICIES, ETC.)

HAVE YOU APPLIED FOR FINANCIAL ASSISTANCE THROUGH ANY OF THESE PUBLIC PROGRAMS?

PROGRAM	DATE OF APPLICATION	STATUS OF APPLICATION			COMMENTS
		APPROVED	DENIED *	PENDING	
MEDICAL					
MEDICARE					
M.I.A. (MEDICALLY INDIGENT ADULT)					
TSAC / MADDY					
BCCTP (BREAST & CERVICAL CANCER TREATMENT PROGRAM)					
EVERY WOMAN COUNTS					
CCS (CALIFORNIA CHILD SERVICES)					
SSI / SSDI / SDI (PLEASE CIRCLE ONE)					
OTHER					
*IF APPLICATION WAS DENIED, PLEASE PROVIDE COPY OF DENIAL					

Financial Information

HAS YOUR ANNUAL INCOME AND/OR EXPENSES CHANGED SIGNIFICANTLY FROM LAST YEAR? YES (PLEASE EXPLAIN BELOW) NO

SIGNIFICANT CHANGES IN INCOME AND/OR EXPENSES

Income of All Family Members Living in the Home

	MONTHLY INCOME	YEARLY INCOME
WAGES		
ALIMONY / CHILD SUPPORT		
UNEMPLOYMENT		
STATE DISABILITY		
WORKERS' COMPENSATION		
SOCIAL SECURITY INCOME		
PUBLIC ASSISTANCE		
INTEREST / DIVIDENDS		
RENTAL INCOME		
OTHER		
TOTAL INCOME		

Expenses of All Family Members Living in the Home

	MONTHLY EXPENSES	YEARLY EXPENSES
MORTGAGE / RENT		
FOOD		
GAS		
UTILITIES		
CREDIT CARD(S)		
LOAN PAYMENT(S)		
INSURANCE		
PROPERTY TAXES		
ALIMONY / CHILD SUPPORT		
OTHER		
TOTAL EXPENSES		



Financial Information, Continued

ASSETS	VALUE	DEBTS, CREDIT CARDS, MORTGAGE, ETC.	
BANKS		PAYABLE TO WHOM	BALANCE
CHECKING			
SAVINGS			
INVESTMENTS			
STOCKS			
NOTES			
OTHER			

	DESCRIPTION	VALUE
REAL PROPERTY DESCRIPTION & VALUE (HOMES/RENTALS)		
AUTO DESCRIPTION & VALUE (MAKE, MODEL, YEAR)		

MEDICAL EXPENSES	AMOUNT
ESTIMATED COST OF CARE	
ESTIMATED INSURANCE COVERAGE	
UNEXPECTED EXPENSES OTHER THAN MEDICAL (DESCRIPTION & AMOUNT)	

I HEREBY SUBMIT THE ABOVE STATEMENT FOR THE PURPOSE OF THE RIDLEY-TREE CANCER CENTER/SANSUM CLINIC TO EVALUATE MY FINANCIAL STATUS AND DETERMINE MY ELIGIBILITY FOR VARIOUS FINANCIAL ASSISTANCE PROGRAMS, AND DO HEREBY AUTHORIZE RIDLEY-TREE CANCER CENTER/SANSUM CLINIC TO VERIFY THIS INFORMATION AS NECESSARY, WHICH MAY INCLUDE EMPLOYMENT AND/OR INCOME VERIFICATION, AND APPROPRIATE DOCUMENTS. I ATTEST THAT THE ABOVE INFORMATION AND ALL INCOME DOCUMENTATION PROVIDED ARE COMPLETE AND ACCURATE AS SHOWN. I REALIZE THAT SHOULD, AT ANY TIME, ANY OF THIS INFORMATION PROVE TO BE FALSE, ALL PATIENT ASSISTANCE GRANTS AWARDED MAY BE REVERSED, AND I WILL ACCEPT RESPONSIBILITY FOR FULL AND IMMEDIATE PAYMENT OF ANY AND ALL OUTSTANDING BALANCES. BY APPLYING FOR FINANCIAL ASSISTANCE, I ALSO AGREE TO ACCEPT PAYMENT RESPONSIBILITY FOR ANY AMOUNT DUE FROM ME AS A RESULT OF ANY PARTIAL PATIENT ASSISTANCE GRANT, WHICH MAY BE AWARDED.

SIGNATURE _____ PRINTED NAME _____ DATE _____

- PLEASE SUBMIT A COPY OF THE FOLLOWING INFORMATION WITH YOUR APPLICATION FOR ALL HOUSEHOLD MEMBERS :
- CURRENT W-2 AND COPY OF MOST RECENT FEDERAL TAX RETURN
 - STATEMENT OF SOCIAL SECURITY BENEFITS
 - STATEMENT OF PENSION BENEFITS
 - STATEMENT OF SHORT AND/OR LONG TERM DISABILITY BENEFITS
 - STATEMENT OF ALIMONY AND/OR CHILD SUPPORT RECEIVED
 - UNEMPLOYMENT COMPENSATION BENEFIT LETTER
 - BANK STATEMENTS FOR PREVIOUS 3 MONTHS
 - PAY STUBS FOR PREVIOUS 3 MONTHS

Return Completed form with supporting documentation to: Ridley-Tree Cancer Center/Sansum Clinic, Attn: Charity Care Coordinator, PO Box 62106, Santa Barbara, CA 93160