Ridley-Tree Cancer Center

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 is able to provide the highest level of cancer 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.

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: ☐ EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ 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'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: ☐ EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ 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

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Insurance Information

☐ I HAVE NO INSURANCE COVERAGE, INCLUDING MEDI-CAL 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	
MEDI-CAL					
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 CIRLCE 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 <u>All</u> 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 <u>All</u> 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		

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Financial Information, Continued

ASSETS	VALUE
BANKS	
CHECKING	
SAVINGS	
INVESTMENTS	
STOCKS	
NOTES	
OTHER	

DEBTS, CREDIT CARDS, MORTGAGE, ETC.	
PAYABLE TO WHOM	BALANCE

	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 TO EVALUATE MY FINANCIAL STATUS AND DETERMINE MY ELIGIBILITY FOR VARIOUS FINANCIAL ASSISTANCE PROGRAMS, AND DO HEREBY AUTHORIZE RIDLEY-TREE CANCER CENTER 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, Attn: Charity Care Coordinator, PO Box 62106, Santa Barbara, CA 93160