# 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, 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.

## 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 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: ☐ 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 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** | | |

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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 SANSUM CLINIC** TO EVALUATE MY FINANCIAL STATUS AND DETERMINE MY ELIGIBILITY FOR VARIOUS FINANCIAL ASSISTANCE PROGRAMS, AND DO HEREBY AUTHORIZE 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: Sansum Clinic, Attn: Charity Care Coordinator, PO Box 62106, Santa Barbara, CA 93160**