CHRISTIANA CARE

Financial Assistance Application Packet

Christiana Care serves our neighbors as respectful, expert, caring partners in their health. We are committed to making care affordable and we offer discounts, payment options and financial assistance to people who cannot afford to pay for medical care, including Emergency Department services and dental procedures requiring hospitalization.

You may be eligible for financial assistance if you are uninsured or underinsured. You must meet the following guidelines:

- You are not eligible for government assistance (for example, Medicare, Medicaid, Medicaid Managed care payers such as United Health, Unison, Blue Cross Health Access).
- Can provide documentation to support financial assistance eligibility.
- You are insured but on a fixed income that meets the thresholds for Financial Assistance and have out-of-pocket expenses.
- You must disclose all insurance benefits available to you or your dependents.

About the Financial Assistance Application Process

1. Complete the Financial Assistance Application checklist and Application form.
   - Proof of income, number of household members and supporting documentation are needed before a financial assistance application can be reviewed.
2. We will review your submitted application and determine if you will qualify for our Financial Assistance Program. ***All financial assistance is based upon current federal poverty guidelines.***
3. We will contact you by letter within 14 days informing you of your eligibility status. We may also contact you if additional information is needed prior to providing a decision.
4. If it is determined that you do not qualify for our Financial Assistance Program, we will review a payment plan that will allow you to establish a monthly payment within balance thresholds established by Christiana Care.

Submitting Your Application

Mail your completed checklist and financial application form, with all required documentation and signatures to:

Christiana Care Health Services
Attention: Financial Assistance
PO Box 2653
Wilmington, DE 19805

If you have any questions, please call **302-623-7440** to speak with a financial assistance representative. Additional information is also available on **www.christianacare.org/financial-assistance**.

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Financial Assistance Application Checklist

Your application must include this checklist as well as copies of all corresponding documentation.

1. If you have no income:

- ❑ Please have the person or person's who provides your support send a letter explaining that they support you, but do not claim you as a dependent on their taxes.

2. If you have been denied Medical Assistance:

- ❑ If you have been denied Medical Assistance through the State, please send us a copy of your 'Letter of Denial.' ***We cannot finalize your application without this letter***.

3. If you have income:

If you file a federal income tax return you must:

- ❑ Attach a copy of your most recent Internal Revenue Service Tax return; i.e. (IRS 1040 Form).

If you did not file a federal income tax return you must:

- ❑ Document below that you are not required to file and the reason why. _____

_____

_____

Did someone claim you as a dependent on their federal income tax return? If yes, you must:

- ❑ Include a copy of the most recent federal income tax return of anyone who claimed you as a dependent.

Additional documentation required, if applicable:

- ❑ Social Security 1099 forms (annual statement).
- ❑ Unemployment or workers' compensation award letters.
- ❑ Disability compensation award letters (annual statement).
- ❑ Pay stubs for the last three months.
- ❑ Most recent IRS Form 1040 and appropriate schedules.
- ❑ If you are self-employed, you must include a Schedule C and/or profit and loss statement.

Did you complete and sign the Financial Assistance Application?

- ❑ Please make sure to complete all the parts of the form that apply to you.

CHRISTIANA CARE

Financial Assistance Application

Reference # (Christiana Care use only):	
Patient Name:	Spouse's Name:
Patient's Social Security Number:	Spouse's Social Security Number:
Patient's Date of Birth (MM/DD/YYYY):	Spouse's Date of Birth (MM/DD/YYYY):
Address (Number and Street/City/State/Zip):	
Daytime Phone Number:	Alternate Phone Number:
Employer's Name:	Spouse's Employer's Name:

Please list your account number(s) for hospital and/or Employed Christiana Care Physicians' Services below, if they are known to you.

Household Information: List ALL dependents claimed on your most recent tax form (i.e. 1040)

Names:	Relation to Patient:	Age:
Total number of household members (including the patient):		

Do you have health insurance?

If yes, please enclose a front and back copy of your insurance card(s). ❑ Yes ❑ No

Did you apply for Medical Assistance in the past six months?

If yes, please enclose a copy of the 'Letter of Denial' or proof of eligibility. You may be required to complete a state Medical Assistance Application, if we determine that you may be eligible for Medical assistance. ❑ Yes ❑ No

Were these services related to an auto accident, worker's compensation or any third party litigation?

❑ Yes ❑ No

If yes, please check appropriate box and complete the information below:

❑ Auto ❑ Workers' compensation ❑ Other

Attorney Name: _____ Phone _____

Address: _____

Are you eligible for the following:

- ❑ Healthcare Connection Program (formally CHAP) ***Date of Eligibility:*** _____
- ❑ Screening for Life ***Date of Eligibility:*** _____
- ❑ Other: _____

If Yes, please provide documentation which supports eligibility.

Patient Understanding:

I understand that the documentation requested will not be returned to me.

I understand that the information provided by me will be used to determine financial assistance and financial responsibility for my services at Christiana Care or for any employed Christiana Care Practice or Physician.

I further understand, that the information I submit concerning my annual household income and size is accurate and subject to verification by Christiana Care.

I understand to cooperate with the application process for State Medical Assistance if requested to do so by Christiana Care, before I will receive financial assistance through Christiana Care.

I understand, if I am approved for financial assistance but later obtain Insurance during my eligibility period, I must contact (302) 623-7440 with this updated insurance information.

I understand that I will be financially liable for any services not covered through financial assistance.

I understand that upon receipt of a financial assistance approval letter, my financial assistance coverage will only be valid for one year from the date of the letter and as a courtesy Christiana Care will adjust balances one year prior to my approval date.

I understand that if I do not qualify for financial assistance, I will establish a monthly payment plan for all of my outstanding accounts based upon balance thresholds established by Christiana Care.

I understand that if any information I have provided is determined to be false, it may result in reversal of my financial assistance approval and I will be liable for all charges.

I grant permission for Christiana Care to verify any of the information I have provided, including but not limited to a credit inquiry, if necessary.

_____ _____

Signature of Applicant *Print Name*

_____ _____

Relationship to Patient *Date*