CHRISTIANA CARE HEALTH SERVICES

Financial Assistance Application

Christiana Care Health Services (CCHS) 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 residents 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 need to disclose all income and insurance benefits available to you or your dependents.
- You are a resident of Delaware or our four neighboring counties. This includes Cecil, Salem, Delaware and Chester Counties. This population will be referred to as "residents" for the purpose of this application.
- You can provide documentation to support financial assistance eligibility and resident status.

The Financial Assistance Application Process:

1. Complete the Financial Assistance Application Checklist and Application form and provide supporting documentation.
    - Proof of gross 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. **Financial assistance review and approval is based upon all gross income reported including IRS schedules compared to federal poverty threshold limits.**
3. We may contact you if additional information is needed prior to issuing a decision.We will request you apply for state medical assistance if determined potentially eligible, prior to issuing financial assistance.
4. If it is determined that you do not qualify for our Financial Assistance Program, we will consider your eligibility to participate in a payment plan allowing you to make payments within monthly balance limit thresholds.
5. If you qualify, you will receive a financial assistance approval letter. Financial assistance coverage will be valid for one year.

Submitting Your Application

Mail your completed financial application 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**.

Do not return this page

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Your application must include this checklist as well as all corresponding documentation: (please submit copies only, originals should not be submitted)

1. If you have no income and your age is less than 65:

❑ You may be eligible to apply for State Medical assistance. Please contact the Division of Health and Social Services to be directed to your local Office for the completion of a medical assistance application. We cannot consider your application for Financial Assistance unless this step is completed.

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 will not review your application without this letter**.

2. 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) with all appropriate schedules (e.g. Schedules c, d, e,) and W2.

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

❑ Provide the IRS Non-filing Form 4506-T which may be obtained from IRS.gov

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.

3. Insurance:

❑ Do you have primary and secondary health insurance? ☐ Yes ☐ No
❑ If Yes, please provide name of Insurances and ID# _____
❑ Are you eligible for State Medical Assistance (Medicaid)? ☐ Yes ☐ No
❑ If Yes, Medicaid ID# _____Date of Eligibility: _____
❑ If No, did you apply for Medical Assistance in the past six months? ☐ Yes ☐ No
❑ If Yes and Medicaid was denied, enclose a copy of the "Letter of Denial".
❑ Were these services related to an auto accident, worker's compensation or any third party litigation? **If Yes,** please check appropriate box. ☐ Auto ☐ Workers' compensation ☐ Other
❑ Representing Attorney Name: _____Phone _____
❑ Attorney address:_____

4. Additional documentation required (as applicable):

❑ All Current Bank Statement(s) Pay stubs for the last three months
❑ Government issued Identification for Patient & Spouse (for example; driver's license, Passport, Visa, Permanent resident card).
❑ Copies of Insurance cards (front and back)
❑ Most recent IRS Form 1040 and appropriate schedules and W-2's
❑ SSA 1099 forms (annual statement)
❑ Unemployment or workers' compensation award letters
❑ Pension, Retirement, Alimony Statements, Veteran benefits statements

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Patient Name:	Spouse's Name:
Patient's Social Security Number:	Spouse's Social Security Number:
Telephone Number:	Telephone Number:
Patient U.S Citizen □ Yes □ No Patient Legal Permanent Resident □ Yes No	Spouse U.S Citizen □ Yes □ No Spouse Legal Permanent Resident □ Yes □ No
Patient's Date of Birth (MM/DD/YYYY):	Spouse's Date of Birth (MM/DD/YYYY):
Address (Apt #, PO BOX, Street , City State, Zip)	

Please provide all applicable identifications (Current driver's license, Passport, Visa, Permanent resident card,) as part of application.

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 Health Services (CCHS) or for any employed CCHS Physician Practice. I further understand that the information I submit concerning my annual gross household income, household size and resident status is accurate and subject to verification by CCHS. I understand I must cooperate with the application process for State Medical Assistance; if requested to do so by CCHS, before I will be consider for financial assistance through CCHS. 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 be valid for one year and as a courtesy CCHS will adjust balances one year prior to my approval date. I understand a new application is needed after one year. I understand that if I do not qualify for financial assistance, I shall establish a monthly payment plan for all of my outstanding accounts based upon balance thresholds established by CCHS. I understand that if any information I have provided is determined to be false, it will result in reversal of my financial assistance approval and I will be liable for all charges. I grant permission for CCHS to verify any of the information I have provided, including but not limited to a credit inquiry, if necessary.

_____ _____

Signature of Applicant **Date Signed**

Print Name _____

CCHS Use Only_____ _____