Confidential Application For Financial Assistance

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Seasons Hospice & Palliative Care ("Seasons Hospice") encourages you to apply for financial assistance if you require help paying for your hospice care. Under this program, Seasons Hospice will review your application and determine whether you qualify for free or reduced cost care based on your eligibility and income. If you have questions or need help completing this application, please contact your Seasons Hospice team, or the National Patient Funding Advocate at 224-458-7405.

Submit completed form to NATFinancialAssistance@Seasons.org

Patient Name:	Date of Birth:
Street Address:	Telephone:
City/State/Zip	Social Security Number:
Mailing Address (if different):	

Citizenship status. Select one

☐ US Citizen ☐ Non US Citizen ☐ Working Visa ☐ Permanent Resident ☐ Visitor Visa:

If Permanent Resident; number of years in the US?

_____

Please provide the following for all household members

Name	Age	Relationship to Patient

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Application

Do you have insurance?	Yes ☐	No ☐	If Yes, list all active policies	
If No, did you apply for insurance through the Health Insurance Marketplace?	Yes ☐	No ☐	If No, please provide a brief explanation as to why you did not enroll	
Do you have Medicaid?	Yes ☐	No ☐	If Yes, list ID and case worker information	
Have you ever applied for Medicaid?	Yes ☐	No ☐	If No, why? If Yes, why was your case denied?	
Do you receive any other assistance with your Medical bills?	Yes ☐	No ☐	If Yes, list organization name and contact information	
Have you applied for disability?	Yes ☐	No ☐	If Yes, When?	
Is there a member of the household who has become unemployed within the past 60 days?	Yes ☐	No ☐	If Yes, Name?	
Have you ever been covered under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA insurance)?	Yes ☐	No ☐	If yes, when did that coverage end?	

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Assets

Report any income for the patient and any individual that may be claiming or may have been claimed by the patient as a dependent for tax purposes.

Assets		Value
Cash on Hand		$
Checking Account Balance	Bank:	$
Savings Account	Bank:	$
Retirement Savings	Bank:	$
Investments or Other Securities		$
Life Insurance Policy Cash Value		$
Real Estate, Primary Residence	Location:	$
Real Estate other than Primary Residence	Location:	$
Vehicle 1	Year:	$
Vehicle 2	Year:	$
Total Assets: $		

Employment

Person Employed	Employer	Monthly Gross
		$
		$
		$

Monthly Household Income from other sources

Source	Monthly
Child Support/ Alimony	$
Federal Assistance Program Type_____ (ie. Cash, Food Stamps)	$
Pension/ IRA/ Annuity Cash out	$

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Social Security/Social Security Disability	$
Unemployment or Worker's Comp Start Date:_____ End Date:_____	$
Other income (Stocks/Bonds/Annuities/Interest/Rental Property)	$
Total month income (Gross and Other sources combined): $	

If the patient does not have any income, provide a short narrative as to who is financially supporting the patient:

_____

_____

_____

_____

Monthly Household Expenses

Type of Expense	**Total Monthly**
Mortgage	$
Rent	$
Child care	$
Child support/ Alimony	$
Utilities (combined) gas, electric, water, sewer	$
Telephone	$
Insurance: Home_____ Auto_____	$
Car loan:	$
Transportation:	$
Credit card payments:	$
Total monthly expenses: $	

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Applicant Certification:

I certify that the above information is true and complete to the best of my/our knowledge. I understand that as part of the financial screening process, Seasons Hospice may require that I provide supporting documentation regarding my finances.

I also understand that Seasons Hospice may require that I seek to obtain health insurance coverage through State Medical Assistance or a federal or state health insurance exchange prior to approving my request for financial assistance.

I am aware that any misstated, missing, or false information can retroactively revoke any financial assistance allowance made by Seasons Hospice. I authorize Seasons Hospice to obtain copies of my tax returns from the Internal Revenue Service.

I understand that filling out this Financial Assistance Application does not guarantee that I will receive any financial assistance. If I am not eligible for financial assistance, I will be responsible for my full bill for hospice services provided by Seasons Hospice.

Signature: _____ Date: _____

Spouse signature (if applicable): _____ Date: _____

Surrogate/DPOA signature (if applicable): _____ Date: _____