



Confidential Application For Financial Assistance

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Seasons Hospice & Palliative Care (“Seasons Hospice”) encourages you to apply for financial assistance if you are experiencing financial hardship 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. If you have questions or need help completing this application, please contact your Seasons Hospice team. Return the completed application to your Season Hospice team, or to NATFinancialAssistance@Seasons.org for review.

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 legally married spouse and dependent household members

Name	Age	Relationship to Patient



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Application

Do you have Insurance?	Yes	No	List all active policies	
Have you ever applied for coverage through the Healthcare Insurance Marketplace?	Yes	No	If yes, when did that coverage end? If no, please provide a brief explanation as to why you did not enroll	
Have you ever applied for Medicaid?	Yes	No	If yes, why was your application denied?	
Do you have a pending Medicaid application?	Yes	No	If yes, please provide the following detail	<ol style="list-style-type: none"> 1. When was your application submitted? 2. Where was your application submitted? 3. Was your application for Medical Assistance, or limited to Emergency Services only? 4. Who submitted your application?
Do you receive assistance with your Medical bills?	Yes	No	If yes, list the organization and contact information	
Have you ever applied for disability?	Yes	No	If yes, when?	
Is there a member of your household who has become unemployed in the last 60 days?	Yes	No	If yes, which member and when?	
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

Financial Detail:

Report any Assets or Income for the patient, legally married spouse, or 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	\$



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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): \$	

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: _____