FOX CHASE CANCER CENTER
TEMPLE HEALTH

CHARITY CARE/FINANCIAL ASSISTANCE APPLICATION

Section I: Required Questions:

Please complete all questions in this section. Failure to complete this section could result in delays in evaluating eligibility for charity care or financial assistance.

A. Patient Information

Patient Name: _____ Date of Birth:_____

Patient Social Security Number: _____

Street Address: _____

City/State/Zip: _____

Home Telephone: _____Mobile Telephone: _____

Are you a legal resident of the State of Pennsylvania?_____YES _____NO

Do you currently have health insurance? (circle one) **YES NO** If yes, provide information below:

Current Health Insurance Company Name: _____

Policy Number: _____Group Name/Number: _____

Name of Subscriber: _____

B. Household Members

Please attach additional sheets of paper if household has more than six members.

	Name:	Relationship:	Age:
1.	_____	Self	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

C. Monthly Household Income

Wages/Salaries *(Before Taxes)*: _____ Pensions: _____

Self-Employment: _____

Social Security: _____ Other Disability: _____

Veteran's Administration (VA) Benefits:_____

Unemployment Compensation: _____ Worker's Compensation: _____

Child Support: _____ Spousal Support: _____

Other Unearned Income *(includes Annuities, Trusts, Interest/Dividends, etc)*: _____

D. Household Countable Resources

Please list your available accounts and liquid assets for your household. A liquid asset is defined as cash or any type of negotiable asset that can be converted quickly and easily into cash. Do not include your home, household items, vehicles, IRAs, 401(k) accounts and other non-liquid assets.

Certificates of Deposit: _____ Stocks or bonds: _____
Trust Fund: _____ Savings account: _____
Checking Account: _____ Savings Certificates: _____

U.S. Savings Bonds: _____ Christmas or Vacation Club:_____

Heath Savings Account (HSA):_____ Other *(Please Explain)*:_____

Section II: Optional Questions

If you so choose, please answer the questions below to provide a better understanding of your ability to pay for medical care. Higher-than-average or otherwise unusual expenses may result in a deduction from total income on your application. Lower-than-average expenses will not result in an increase of income

A. Monthly Household Expenses

Mortgage/Rent: _____ Property Taxes: _____

Insurance: _____ Auto Loan/Lease: _____

Gas/Oil Heating: _____ Electric: _____

Water: _____ Telephone/Internet: _____

Child Support: _____ Spousal Support: _____

Other *(Please Explain)*:_____

_____

B. Monthly Medical Expenses

Insurance Premiums: _____ Medical Equipment: _____

Doctors' Visits: _____ Prescriptions: _____

Other *(Please Explain)*: _____

Section III: Verification of Income and Countable resources

Please attach proof of income current resources to this application. Please verify all income and resources listed in Section One. If you are unable to verify some or all of your income or resources, please explain why on an attached sheet of paper. Applications will not be rejected for inability to verify income or resources, provided that reasonable explanation for the inability is given. Acceptable sources of verification include, but are not limited to:

- Pay stubs for the last 60 days or letters from employers, listing wages before taxes. If self-employed - copy of last income tax return including all attachments.
- Award letters or bank statements showing deposits of Social Security, other disability, pension, worker's compensation, or unemployment compensation payments.
- Award letters, court documents, or bank statements showing deposits of child or spousal support payments.

Documentation of other sources of income

- If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide (e.g., grocery purchases or rent and utility payments).
- Health Savings Account (HSA) and other dedicated account statements.
- Checking and Savings account statements for last 2 months.
- Copy of Health Insurance Card(s), if applicable

Section IV: Certification

Please sign and return the completed application with the items listed in Section III to:

Fox Chase Cancer Center
Financial Counseling Department
333 Cottman Avenue
Philadelphia PA, 19111

I understand that by signing this document I am applying for Charity Care or Financial Assistance at Fox Chase Cancer Center and agree to pay any balances not covered 100 % by Charity Care. I certify that the above information is true and accurate to the best of my knowledge. I also understand that Fox Chase Cancer Center may verify the information I am providing. I will cooperate with this verification and provide all needed evidence to support the information I have declared on this application. I understand that willful falsification of information contained in this application will result in denial of assistance Also, I agree to inform the Hospital Financial Counseling Department of any change in my insurance eligibility, income, living arrangements, or address as they occur.

Applicant Signature_____**Date**_____