ChristianaCare

## Community Assistance Program

The Community Assistance Program, as sponsored by ChristianaCare, Union Hospital, offers hospital services, as well as physician services at multi-specialty practices, at a reduced cost based on a patient's inability to pay. The Community Assistance Program is a patient centered program to help eliminate your fear and anxiety regarding your medical bills. This is not an insurance program, and only provides assistance on approved outstanding balances at the Cecil County Christiana Care campus. The application process is simple and straightforward.

The Community Assistance Program is a consistent and equitable process designed to grant financial assistance to appropriate patients while respecting the individual's dignity. If approved, your balance will be adjusted between 25% - 100% based on Federal Poverty Guidelines. Eligibility shall include medical care for twelve months prior to and continue for up a maximum of twelve months forward.
To see if you qualify, just follow the steps below:

## Guidelines for Eligibility

- If not employed and uninsured, you must apply for either Medicaid or private coverage through your State's Health Insurance Exchange. You may be required to provide proof of denial for insurance programs to be eligible for financial assistance through ChristianaCare, Union Hospital.
- If employed and uninsured you must enroll in an employment-based health plan if available. If insurance is not available, you must apply for insurance coverage through your State's Health Insurance Exchange during eligible enrollment periods.
- Failure to enroll in eligible health insurance plans may result in the denial or termination of your Financial Assistance.
- If you have completed all of the above and remain uninsured, you may be eligible for assistance.
- Meet income guidelines. Based upon Federal Poverty Guidelines.

## Guidelines for Applying

The first step is to complete a Community Assistance Application and provide the following supportive documentation:

- 2 most recent copies of all pay stubs, unemployment benefits, social security checks, cash assistance checks, alimony, or child support checks.
- 2 months of most recent checking and savings account statements and/or financial records for all accounts you are associated with.
- Copy of Federal AND State Income Tax return, as well as W2. You must provide a signed statement indicating if you do not file taxes.
- If uninsured, proof of denial for health insurance through your State's Health Insurance Exchange, through your State for Medicaid, or if you or your spouse is employed, proof that the employer does not offer health insurance.
- Copy of letters of any awarded benefits you are currently receiving including: Food Stamps, TCA, or Energy Assistance.
- A letter of support (preferably notarized) if no evidence of income.

When all information is gathered, a Financial Counselor will do a preliminary review and verify your eligibility, at which time additional documentation may be requested by correspondence. Failure to provide the requested documentation within a specified time frame may result in your application being denied. If you need help applying for any State of Maryland health insurance programs, a representative is on site at ChristianaCare, Union Hospital to assist you. If you have any questions, please feel free to contact one of our Financial Counselors at **410-392-7033**.

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# ChristianaCare, Union Hospital Financial Assistance Application
# For Information Call 410-392-7033

## *Information About You*

Name _____
First Middle Last

Social Security Number_____ Marital Status: □ Single □ Married □ Separated
US Citizen: □ Yes □ No Permanent Resident: □ Yes □ No

Home Address_____ Phone_____

_____
City State Zip Code Country

Employer Name _____ Phone_____

Work Address

_____
City State Zip Code Country

### Household members:

Include married spouse, dependent children, or any other household members on your tax return

_____
Name Age Relationship

_____
Name Age Relationship

_____
Name Age Relationship

_____
Name Age Relationship

_____
Name Age Relationship

_____
Name Age Relationship

_____
Name Age Relationship

_____
Name Age Relationship

Have you applied for Medical Assistance? □ Yes □ No

If yes, what was the date you applied? _____

If yes, what was the determination? _____

_____

Do you receive any type of state or county assistance? □ Yes □ No
(Food stamps, Energy Assistance, Temporary Cash Assistance, WIC, SLMB, Free or Reduced Lunch Program)

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## *Family Income*

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

| | Monthly Amount |
|---|---|
| Employment | _____ |
| Retirement/pension benefits | _____ |
| Social security benefits | _____ |
| Public assistance benefits | _____ |
| Disability benefits | _____ |
| Unemployment benefits | _____ |
| Veterans benefits | _____ |
| Alimony | _____ |
| Rental property income | _____ |
| Strike benefits | _____ |
| Military allotment | _____ |
| Farm or self-employment | _____ |
| Other income source | _____ |
| **Total** | _____ |

## *Liquid Assets*

| | Current Balance |
|---|---|
| Checking account | _____ |
| Savings account | _____ |
| Stocks, bonds, CD, or money market | _____ |
| Other accounts | _____ |
| **Total** | _____ |

## *Other Assets*

If you own any of the following items, please list the type and approximate value.

| | | |
|---|---|---|
| Home | Loan Balance _____ | Approximate value _____ |
| Automobile | Make_____ Year_____ | Approximate value _____ |
| Additional vehicle | Make_____ Year_____ | Approximate value _____ |
| Other property | | Approximate value _____ |
| | | **Total** _____ |

## *Monthly Expenses*

| | Amount |
|---|---|
| Rent or Mortgage | _____ |
| Utilities | _____ |
| Car payment(s) | _____ |
| Credit card(s) | _____ |
| Car insurance | _____ |
| Health insurance | _____ |
| Other medical expenses | _____ |
| Other expenses | _____ |
| **Total** | _____ |

Do you have any other unpaid medical bills? □ Yes □ No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ _____

Applicant Signature Date

_____ _____

Applicant Print Name Relationship to Patient

Please mail or bring in the completed form to:

**CHRISTIANACARE, UNION HOSPITAL**

Patient Financial Services – Financial Assistance

106 Bow Street

Elkton, MD 21921

For information or assistance please call:

Patient Financial Services 410-392-7033

Additional information and forms may be found on our web site:

www.uhcc.com