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. To see if you qualify, just follow the steps below:

Guidelines for Eligibility

- You need to disclose all gross income and insurance benefits available to you or your dependents.
- 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.
- Meet income guidelines. Based upon Federal Poverty Guidelines.
- Resident of Cecil, Harford, or Kent County in Maryland or in one of the following neighboring counties: New Castle, Kent, Sussex County in Delaware; Chester, Delaware, or Lancaster County in Pennsylvania; and Salem County in New Jersey. This population will be referred to as "residents" for the purpose of this application.

The Community Assistance Program Process

1. The first step is to complete a Community Assistance Application and provide the following supportive documentation:
   - Proof of gross income, number of household members and supporting documentation are needed before a financial assistance application can be reviewed.
2. A Financial Counselor will review your submitted application and determine if you will qualify for our Financial Assistance Program. The financial assistance criteria related to gross income is based upon federal poverty guidelines.
3. We may contact you if additional information is needed prior to issuing a decision.
4. We will request you apply for state medical assistance if determined potentially eligible, prior to issuing financial assistance. 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.
5. Failure to provide the requested documentation within a specified time frame may result in your application being denied.
6. 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.
7. If you qualify, you will receive a financial assistance approval letter. Financial assistance coverage will be valid for one year.

Submitting Your Application

You may submit your application and documents by mailing your completed financial application with all required documentation and signatures to:

CHRISTIANACARE, UNION HOSPITAL
Patient Financial Services – Financial Assistance
106 Bow Street
Elkton, MD 21921
E-Fax to 302-327-7516 or
Email to Financialassistance@christianacare.org

If you have any questions, please feel free to contact one of our Financial Counselors at **410-392-7033**.
Additional information and forms may be found on our web site: www.uhcc.com

Do not return this page

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Community Assistance Program

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

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

❒ You may be eligible to apply for State Medical assistance. 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.

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 Verification of Non-Filing Letter 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.

Additional documentation required (as applicable):

❒ SSA1099 form (annual statement)
❒ 2 most recent copies of all pay stubs, unemployment benefits, social security checks, cash assistance checks, alimony, or child support checks.
❒ 3 months of most recent checking and savings account statements and/or financial records for all accounts you are associated with.
❒ If uninsured, proof of denial for health insurance through your State's Health Insurance Exchange, through your State for Medicaid,
❒ 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.
❒ Copies of Insurance cards (front and back)
❒ Government issued Identification for Patient & Spouse (for example, driver's license, Passport, Visa, Permanent resident card)

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 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:_____

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ChristianaCare, Union Hospital Financial Assistance Application

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

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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