

THIS APPLICATION MAY ONLY BE SUBMITTED BY A CSA PARTICIPATING FACILITY.



**GEORGIA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF CANCER SCREENING AND TREATMENT
CANCER STATE AID FINANCIAL APPLICATION**

Form 3621F - Revised 2/13

Mail to: **Cancer State Aid Program (CSA)**
Two Peachtree Street, NW, Suite 16-453
Atlanta, Georgia 30303

FY2014

Phone: 404-463-5111 Fax: 404-657-6316

SECTION I - Facility & Reviewer Information

Reviewer's Name and Title:		Date of Application Completion:
Signature attesting to good faith attempt to obtain accurate information/documentation:		Reviewer's direct phone number & extension:
Facility (site) Name:	City:	Reviewer's FAX number:
Reviewer's/Facility (site) Mailing Address:		

SECTION II - Patient Information

Last Name		First Name		MI	Maiden Name
Street Number	Street Name			Apartment #	
City		State GA	Zip Code		County
Primary Phone number			Alternate Phone Number		
Date of Birth		Age	Social Security Number		

Requested Start Date for Patient's CSA Enrollment: *If none entered the application completion date is used.*

Check (✓) types, list Names of Other Facilities that will provide treatment for this patient.

- Hospital
 Radiation Ctr
 Pharmacy
 HomeHlth/MdSupply
 Unknown
 NA-no referrals

List other facilities that will provide active cancer treatment to the patient (add pages if needed):

Select ethnicity, then select one race category.

Ethnicity: Hispanic or Latino

- Yes
 No

Race:

- White
 Other
 Unknown
 Black or African American
 American Indian or Alaska Native
 Asian
 Native Hawaiian or Other Pacific Islander

Select only one: Marital Status

- Single
 Married
 Widowed

Select One: An official identification and documentation of legal residency is required.

- U.S. Citizen
 Qualified Alien
www.uscis.gov/blink/.../0-0-0-25404.html

A U.S. Citizen is one who is born in the U.S., is the child (adopted or natural) of a U.S. citizen, or has been granted citizenship status by the Immigration and Naturalization Services (INS).

A Qualified Alien is one who is lawfully admitted to reside permanently in the U.S..

Georgia Resident: Yes No

Sex/Gender: Male Female

- Select One: New Cancer State Aid Patient
 Current or Returning Cancer State Aid Patient

CSA ID Number (current or returning patients only):

Last Date Patient was Enrolled:

Last Name	First Name	MI	Maiden Name
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SECTION V - Monthly Medical Payments, Credits to Income

Ongoing monthly, family medical expenses are subtracted from monthly income as a "credit".
 These are medical expenses paid each month, as out-of-pocket payments by or for family members listed in Section IV.
 List monthly medical expenses and include a description of each item (attach additional sheet if needed):

List all on the application financial worksheet to help determine eligibility.

ITEM (Description):	Monthly Expense
1 Amount paid each month for medical expenses	\$
2	\$
3	\$
4	\$
5	\$
Total medical expenses or credits to monthly income.	\$

Verification must be available upon request.

SECTION VI - Other Resources

Cash/liquid assets: Examples include checking and savings accounts, stocks, certificates of deposit, and real estate or property that does not include ownership of a personal home.

List and provide value calculated using the worksheets for each. **If no accounts or assets are owned, enter "0" (zero).**

List all on the application financial worksheet to help determine eligibility.

1 Include totals calculated from the Real Estate/Property Assets worksheet (enter "0" if none)	\$
2 Include totals calculated from Financial Accounts/Assets worksheet (enter "0" if none)	\$
3	\$
4	\$
5	\$
6	\$
Total amount of cash/liquid assets.	\$

Copies of asset statements must be provided with application.

SECTION VII - Outstanding family medical expenses:

Total amount owed out-of-pocket for medical expenses. Do not include costs covered by other payers.

List names of providers and amount owed to each provider (attach additional sheet if needed):

List all on the application financial worksheet to help determine eligibility.

1	\$
2	\$
3	\$
4	\$
5	\$
Total amount of outstanding medical expenses.	\$

Verification must be available upon request.

SECTION VIII - Agreement

I fully understand that Cancer State Aid Program is intended only for those patients who are unable to pay for cancer related medical services. I hereby certify that the information provided in this application is complete and accurate, and that I am unable to pay for cancer related medical services. I agree to provide notification of changes in my financial eligibility status to the CSA facility submitting this application. I authorize release of any necessary information that is related to my cancer care, documentation for billing, or program evaluation to the Cancer State Aid Program, physicians, and facility. This authorization shall be valid for two (2) years. A copy of this authorization shall be as valid as the original. I acknowledge receipt of a copy of the Department's Notice of Privacy Practices.

Applicant Must Initial: Cancer State Aid funding is limited to facilities for which the patient has received prior approval. Private physician office visits & third party vendors providing services to a hospital, such as laboratory testing, X-rays and others are not eligible for payment. The patient is responsible for payment of unapproved facilities, ineligible providers or services.

Applicant Signature (or mark with witness signature)

Date (required)

Refer to Application Completion Instructions or contact CSA (404-463-5111) for assistance.