FY2014 Cancer State Aid
INSTRUCTIONS for Application Completion (Form 3621F) & Presumptive Eligibility

The CSA **Financial Application Form 3621F** is completed and submitted by postal mail to the Cancer State Aid Program (CSA) on behalf of the patient by designated personnel at a CSA participating provider facility. This designated person is called the "CSA Patient Contact" or "Coordinator", also referred to as the "reviewer". The CSA Patient Contact will verify that the form is complete and accurate prior to submitting the complete application to CSA. CSA only accepts applications submitted by a CSA facility.

Please note that all other supporting financial and medical documentation listed on the application checklist is required for a complete application.

Applications that are incomplete will not be approved and the facility will be contacted to provide all required information. **Applications that remain incomplete may be denied** for lack of required information at the discretion of the Program.

Faxed applications packets are not accepted; due to packet size, only mailed applications are accepted. Please allow up to ten business days for CSA receipt of mailed packets. Please review application packets for completeness before mailing to avoid delays in enrollment decisions.

Once CSA has a waiting list and stops accepting applications for the current fiscal year funding, applications **received** after the application cutoff date, as stated in the CSA Memo, will not be considered.

The facility must retain a copy of all patient application materials in their files at the facility.

Instructions for each section on the Financial Application Form 3621F

◈ Section I: Facility and Reviewer Information

The facility at which the application is completed and who submits the application to CSA is considered to be the patient's "primary" treatment facility. The CSA Patient Contact/Coordinator or "reviewer" at that facility must fully complete this section.

Provide complete information as requested in Section I of the application. This information is used to contact the reviewer with any questions or for additional information that may be needed.

The facility contact/reviewer completing or assisting the patient to complete the application must sign the form in section I.

Eligibility Determination

◈ Section II: Patient Information:

To be eligible for approval for medical treatment reimbursements provided by the CSA program, patients must qualify based on both, financial status and medical condition.

- A **social security number** must be provided if the patient has one. This will be used to check Medicaid eligibility. A patient with Medicaid coverage cannot be approved for, nor continue enrollment in the CSA Program.
- Assigned CSA **Enrollment Date** (Section II – Patient Information on Financial Application): CSA starting dates of enrollment are assigned on an individual basis**.**
  - Those applications that do not include a requested starting date may be contacted to determine an appropriate starting date. CSA may without contacting the "CSA Patient Contact", elect to assign a starting enrollment date based upon information provided, if this is left blank.

- **CSA makes every attempt to approve enrollment date requests.** When funds are very limited or the program has a waiting list, enrollment dates may be limited to the CSA receipt date of complete information.
- Requested start dates exceeding 60 days prior to the CSA receipt date of the application are unlikely to be approved. Payments of existing and new service claims are limited to those dates of service that fall within the approved coverage period.
- To request a different starting date after application approval, please send an email or a letter with a description of reasons the starting enrollment date should be modified. Modifications of enrollment dates are based upon available funds and whether a waiting list for program enrollment has been started.

- **Check all types of facilities** that are known to be needed by the patient for cancer treatments. This information is requested to ensure accurate treatment cost assessments, planning and assignment of CSA funds for each patient's care.
  - List those additional known CSA participating facilities for which the patient will need CSA reimbursement approval for referred cancer treatments. Include all CSA facilities that are anticipated to provide cancer services that CSA may reimburse. A current hyperlinked list of "Cancer State Aid Facilities" is posted on the far right of the CSA main web page located at http://health.state.ga.us/programs/cancerstateaid/index.asp
  - It is expected that the "reviewer" will make a reasonable attempt to provide this information as accurately and completely as possible. If there is no indication of referrals in the patient's available medical records, the reviewer should question the patient about referrals to other facilities that the attending or treating physician may have discussed with the patient.
  - Check (√) all of the types and list all of the names of other cancer treatment facilities that the patient may be referred to for care. CSA prior approval of each facility is required for services to be eligible for payment. If this information is not available, check "unknown".
  - Only check "NA" if the patient will receive all prescribed services and outpatient medications at the "primary" facility (the reviewer's home facility); no referrals to outside treatment facilities will be made.

- **Demographic Information –** All demographic information must be completed (race, ethnicity, marital status, gender).
  - To be eligible for CSA, a patient must be a United States citizen or a qualified alien who is permitted to reside permanently in the United States. All applicants must complete and sign a **GA. Department of Public Health Verification of Residency for Public Benefits** form or for those who speak only Spanish, the Declaration of Citizenship/Legal Alien Status form is also accepted. This form must be included with their application.
  - **Proof of US citizenship is required of all applicants (only one ID is required):** immigration status of all legal permanent alien residents is verified on the federal immigration web site. http://www.dhs.gov/citizenship-and-immigration-services
    - Current or expired U.S. passport (not limited passports)
    - Certificate of Naturalization (N-550 or N-570)
    - Certificate of Citizenship (N-560 or N-561)

- Official US government issued identification such as a driver's license.
- Other documents listed in the Secure and Verifiable Documents under O.C.G.A. 50-36-2 are also accepted. http://rules.sos.state.ga.us/docs/183/1/6/06.pdf

Copy both sides of the card or certificate and submit with each patient's application**; copies must be magnified to be easily readable and must be clean copies without smudges.**

- **Proof of Georgia residency is required of all applicants.** The CSA program is funded by the state legislature and benefits are provided only for Georgia residents.

  The documentation of citizenship may have their home address listed. If not, then you must submit utility bills, banking accounts, medical bills or paycheck stubs displaying the applicant's name and address. Include a copy of only one such document to provide evidence of Georgia residency. If this is not available for homeless or similar patients, a note or letter from the shelter (on letterhead) or person providing shelter for the applicant may be accepted. The note or letter must show that the applicant is a Georgia resident (not a visitor). A resident is defined as one residing in Georgia with the intention of making it their permanent home for the foreseeable future.

- If a patient has not previously applied for approval to enroll in CSA, the patient is a **new** patient. If the patient was approved for CSA at any time in the past, the patient will already have a CSA number. These patients' applications are referred to as a **recertification**. Patients may know whether or not they have been enrolled in the past and may be able to provide an old approval letter. The letter will provide the patient's CSA ID number and approval date. If they do not have access to this number, you may contact the CSA program office to obtain the number. Once assigned, the basic CSA ID number does not change.
- The typical **CSA number** consists of 10 or 11 characters.
  - The first four digits of the CSA number indicate the fiscal year in which the patient was first approved for program enrollment. Please note that the state fiscal year is from July 1 to June 30th, with the calendar year of the ending date, as the fiscal year; e.g. FY2009 is July 1, 2008 to June 30, 2009.
  - The next four or five digits are unique to the patient.
  - The letter portion of the CSA number identifies the site or type of cancer diagnosed.
  - The final number indicates the severity of the cancer at the time of original approval for CSA enrollment.
  - Occasionally, a patient will develop more than one primary cancer site. In those cases, the patient will have an additional letter and number at the end of the core number. The additional letter and number indicate the new primary cancer.
- All treatment must be provided at prior approved CSA participating facilities;
  - Treatments provided at other facilities or CSA facilities that have not been prior approved for the patient are not eligible for payment with CSA funds. Only the treating physicians at CSA facilities may refer patients to other CSA facilities. Please contact CSA to receive prior approval for the patient to be eligible for CSA payments for those referred services and facilities.
  - Physicians must be affiliated with a participating CSA facility, and accept CSA patients for treatment under the CSA coverage terms.

◈ **Section III: Health Insurance Information –** Complete for any insurance the patient may have.

- Patients who currently have any type of health insurance, including Medicare or any other medical benefit coverage must provide documentation of insufficient coverage of needed cancer related medical services.
  - CSA requires a letter from the insurance provider that is on the company letterhead as documentation of insurance coverage. The letter must clearly describe the lack of coverage that has caused the patient to seek CSA funding (e.g. reached maximum or only has partial coverage).
  - Patients with health insurance plans with high deductibles or limits on the number of office visits or limited prescription drug coverage are considered to have creditable coverage and are not eligible for CSA.
  - If the patient is not covered by insurance because the cancer condition is considered by the insurance carrier to be pre-existing, the patient may be eligible for CSA. These applications must be accompanied by documentation from the insurance company verifying insurance coverage limitations and effective coverage dates. If available, copies of letters that deny coverage from the insurance company should be included.
  - If the patient is no longer covered by insurance because the patient's treatment costs have reached maximum benefit coverage limits, the CSA application must be accompanied by verification from the insurance carrier to that effect. The verification must include a date after which benefits will not be paid and a date that the patient will again become eligible for insurance benefits.
  - If the patient has only a limited (supplemental) health insurance policy that is designed to reimburse only a small set amount for specific services, the patient may be considered for CSA. To be considered for CSA, policy information which clearly describes the reimbursement limits and services covered must be submitted for review. Patients will only be considered for CSA enrollment if the health insurance policy pays less than CSA would reimburse for the same service.
  - Patients with comprehensive health insurance are not eligible for CSA. Comprehensive coverage for CSA purposes means that the patient has inpatient and outpatient benefits that cover cancer and cancer related treatment and services.
  - Should a patient lack coverage for inpatient and outpatient components and the patient otherwise qualifies for CSA enrollment, CSA may approve coverage limited to reimbursement of only that component which is lacking.
  - It is the responsibility of the facility's designated Cancer State Aid (CSA) Patient Contact or Coordinator to verify that the patient is not eligible for **Medicaid** or any category of **Medicare**, and does not have other creditable insurance coverage prior to submission of an enrollment application to the program.
  - Patients with Medicare and/or Medicaid are not eligible for CSA enrollment. Some very limited exceptions for Medicare may apply. (See the last two paragraphs of Section III, on page 5.)
- **All other medical benefit coverage programs for which the patient has made application must be indicated.** These include but are not limited to all types of Medicare, Medicaid and Supplemental Security Income (SSI).

- **It is expected** that all patients who apply for CSA coverage have already applied (or will immediately apply) for all other programs for which they may be eligible and that they have either been denied or notification is pending.

In this section of the application you must indicate all insurance or reimbursement programs the patient has applied to and indicate the current status of those applications. Also note the date the applications were submitted. If application was made to other programs which are not listed on the CSA application, briefly describe the program and note the date of that application.

- Do not leave this section blank. **Indicate a response for each listed item.**
- Provide an explanation for all "NA" (Not Applying) responses.
- If any part of this section is left blank the application will not be approved and the facility contact will need to provide additional information.

Medicaid:

Links to brief descriptions and eligibility guidance for all categories of **Medicaid** coverage may be found at: http://dch.georgia.gov/00/channel_title/0,2094,31446711_33935684,00.html and http://dch.georgia.gov/medicaid.

Electronic applications for Medicaid may be found at: https://compass.ga.gov/selfservice/selfserviceLogout?tab=175682.

Printable – hard copy Medicaid applications may be found on the lower third of the web page at: http://dch.georgia.gov/00/article/0,2086,31446711_31944826_163850678,00.html#medicaresavings This web page also has "Medicaid FAQs" to help you understand Medicaid programs that are available.

Link directly to the printable Medicaid application document: http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/43/46/179276979-Medicaid-Application-English.doc

Fact sheets about different assistance programs may be found at: http://dfcs.dhs.georgia.gov/portal/site/DHS-DFCS/menuitem.5d32235bb09bde9a50c8798dd03036a0/?vgnextoid=a1a92b48d9a4ff00VgnVCM100000bf01010aRCRD

Medicaid Eligibility Charts: http://dch.georgia.gov/eligibility-criteria-chart

The CSA Patient Contact should become familiar with the various categories of Medicaid Eligibility to ensure appropriate recommendations for application to Medicaid, and achievement of the most accurate assessment of patients' eligibility for CSA.

Medicare:

For those patients who are eligible for **Medicare** Part A (hospitalization or in-patient service coverage), the facility's CSA Patient contact must determine if it is likely that the patient will also be eligible for Medicare Parts B, C or D. (See #8 in this section below.)

The following descriptions of the different categories of **Medicare** coverage will be helpful in determining patient eligibility. Additional information may be found at http://www.cms.hhs.gov/MedicareGenInfo/ and http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf (60 pages in PDF – download is 3 minutes)

Medicare is a health insurance program for:

- people age 65 or older,
- people under age 65 with certain disabilities, and
- all ages with End-Stage Renal Disease/permanent kidney failure requiring dialysis or transplant.

1. **Medicare Part A** Hospital Insurance - Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

2. **Medicare Part B** Medical Insurance - Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

   *Please note that eligible patients who do not sign up for Part B when they first become eligible will pay a monthly penalty should they choose to enroll in Par B of Medicare at a later date.

3. **Medicare Part C** (Medicare Advantage Plans) (like an HMO or PPO) – A health coverage choice run by private companies approved by Medicare Includes Part A, Part B, and usually other coverage including prescription drugs

4. **Medicare Part D** (Medicare Prescription Drug Coverage) – May help lower your prescription drug costs and help protect against higher costs in the future. Private companies provide this insurance coverage. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

   Patients who are eligible for Part B and/or other parts of Medicare and have difficulty meeting the financial demands of paying the premiums and co-payments for that coverage should apply for Medicaid's "Qualified Medicare Beneficiary" program.

5. Medicare Savings Plans Programs (hyperlink and web address) http://dch.georgia.gov/medicaid-faqs#medicaresavings

   Medicaid's Qualified Medicare Beneficiaries (QMB) is defined as: Aged, blind or disabled individuals who have Medicare Part A (hospital) insurance, and have income less than 100 percent of the federal poverty level and limited resources. **Medicaid QMB will pay the Medicare premiums (A&B), coinsurance and deductibles only.**

QMB Income Limits	QMB Resource Limits
Individual - $978 per month ($11,736 per year) Couple - $1,313 per month ($15,756 per year)	Individual - $7,080 Couple - $10,620

Effective 3-1-2013

6. Facilities' Cancer State Aid Patient Contact in charge of applications to Cancer State Aid should assess the patients' likelihood of becoming eligible for the QMB program using the income and resource limits of the QMB program. http://dch.georgia.gov/eligibility-criteria-chart

7. Patients who are likely to be eligible for the QMB program must be provided information and appropriate assistance to facilitate their application for Medicare and Medicaid QMB enrollment.

Patients are expected to accept all Medicare or Medicaid coverage for which they are eligible. Those applicants who cannot pay the Medicare premiums and co-payments should apply for Medicaid's QMB coverage. Applicants to the Cancer State Aid Program who are denied QMB coverage by Medicaid must submit a copy of the Medicaid QMB denial letter with their Cancer State Aid application.

8. Patients who have voluntarily declined any part of Medicare coverage due to cost, and are in need of coverage for cancer treatment may still apply for Cancer State Aid (CSA).
   - These patients may be provided limited CSA program coverage and will be evaluated on a case by case basis for CSA enrollment.
   - In these cases you must provide to CSA, the date that the patient will again be eligible for Medicare. At that time they should apply for Medicaid's QMB program if it is likely they will be eligible (see #5 above).
   - Any CSA coverage offered will only continue until the patient is again eligible to apply for Medicare benefits or until the stated expiration date of their CSA enrollment period for which they are approved.
   - Patients who have previously declined Medicare coverage and are approved for limited CSA coverage must provide documentation of Medicaid QMB denial to be considered for any future CSA enrollment.

Worksheets are provided to help facilities determine the value of **assets** owned by applicants and their family members.

1. Please refer to the CSA **Financial Accounts**/Assets **Worksheet** for assistance with estimating the value of financial accounts that may be owned by the applicant and their family. Do not include tax deferred retirement accounts.
2. Please refer to the CSA **Real Estate/Property** Assets **Worksheet** for assistance with estimating the value of properties that may be owned by the applicant and their family. Do not include their primary residence. Do not include property that is rented out, this is counted as income.

***Do not submit Asset worksheets if the patient does not have any financial or property assets.**

3. **If no assets, section VI on the application should = 0.**
4. Totals from the asset worksheets should be entered on the application in the appropriate sections and on the **Financial Eligibility Worksheet**.
5. **The Financial Eligibility Worksheet is required with every application.**

◈ Section IV: Family Size and Income

A. Family Size

Family size is defined as the number of immediate family members related by blood, marriage, or adoption to the applicant that reside in the same household. Family size must be determined prior to determination of income. Income verification is required only for persons counted in family size. Although minors do count in family size, income for minors under 18 years of age is not counted in family income.

Use the following guidelines to assist in determination of family size:

- Include those family members that are dependents that rely upon the head of household for support and that are included as dependents on annual family tax filings/returns.
- If the applicant is married, family size shall include the spouse, dependent children under 18 years and related adults 18 years and older who are solely dependent on the applicant or spouse for food, clothing, and shelter.
- If the applicant is a single parent or single head of household, the family shall include dependent children under 18 years of age and related adults 18 years and older who are solely dependent on the applicant for food, clothing and shelter.
- If the applicant is a single adult 18 years or older, residing with adults other than a spouse, or residing alone, this shall be a one-person family unit.
- If an applicant is an adult living with and being supported by extended family or friends and has no other dependents then the family size is one, only the applicant. Do not count the extended family or friends that are providing food and shelter for the applicant as family members for the purposes of CSA application.
- If the applicant is a student 18 years or older and is still listed as a dependent on his parent's income tax return then count this person in the total family size; the family number shall include the parents, and other dependent siblings and/or related adults 18 years and older who are solely dependent on the parents for food, clothing and shelter.

B. Family Income

The patient's family income must not exceed **300%** of the federal poverty levels (FPL) income guidelines for family size for the year in which the patient is applying.

Please review the CSA Poverty Income Guidelines for the fiscal year in which the patient is applying to determine these amounts. Please note that the state fiscal year (SFY) extends from July 1 to June 30.

***Please see the document (#12) titled "Assets and Income Verification Instructions" for types of income and asset verification accepted by CSA.** The facility is expected to obtain and submit copies of income verification with the patient's application.

- Family income listed as zero ($0) must include a clear description of how the patient is meeting daily/monthly living expenses. If this is left blank the application will not be considered and the facility contact will need to provide additional information, causing a delay in the patient's CSA enrollment.
- The patient must provide income verification upon application for enrollment into the CSA Program. **Verification of gross income** must be provided for all family members counted in the family size.
  - Exception: Income dedicated solely for support of minor children is exempt and does not need to be counted towards the total gross family income. Examples include child support and social security income from a deceased parent.
  - *Income verification must be submitted with the application; and updates or changes must be immediately submitted to CSA when they occur and/or the facility learns of them.
  - Income (three months of check stubs) and financial assets (copies of bank statements and/or taxable investment accounts) documentation is required with the application.

- Monthly or other routine distributions from retirement accounts, IRAs, Roth or employer sponsored 401K accounts and other similar investments are to be counted as income. Include a description on the application.
- Monthly payments received from rental property are to be counted as income.
- If rental property (dwellings or land) is not currently rented, the fair market value of the property will be counted as an asset (see Section VI below).

◈ Section V: Monthly Medical Payments, Credits to Income

Ongoing medical expenses include any family member's medical expenses which are paid **monthly,** out-of-pocket by the applicant on a regular recurring basis. These monthly payments or expenses can be *credited* to (subtracted from) the total gross monthly family income.

- Common examples are medical supplies, home health equipment or medical services and medications.
- Payments on outstanding medical bills (for all family members) that are made monthly or at other regular intervals are counted as medical credits or expenses and are deducted from the income on the financial eligibility worksheet.
- Payments for medications and/or other co-payments for medical visits that occur monthly or at other regular intervals are also counted as medical credits to income on the financial eligibility worksheet. Documentation may be requested.
- Ongoing expenses cannot be credited to income without written documentation of these expenses. The patient may provide verification of ongoing expenses to the treatment provider.
  - Copies of documentations should be kept on file with the patient's application at the facility and must be readily available upon request.
  - Do not submit these verifications with the application. If these are needed, CSA will request them.
  - The facility should be able to immediately fax copies to CSA upon request.
- If credits to income are used to establish CSA eligibility for patients that would not otherwise be eligible, documentation of those credits must be submitted with the application.
  - Documentation of credits to income includes copies of medical monthly bill statements showing payments and balance owed; copies of bills and or payments for other family medical expenses.

◈ Section VI: Other Resources/Assets

Assets are items in the possession of the applicant or family household members that can be sold or exchanged for cash by the applicant or family members.

CSA provides **worksheets** to help determine the value of financial accounts and property assets.

Please see "Assets and Income Verification Instructions" for types of income and asset verification accepted by CSA. The facility is expected to obtain and submit copies of income verification with the patient's application.

- Examples of **assets** are stocks, certificates of deposit, savings accounts, bonds, other financial accounts that can be liquidated for the cash value, and any real property other than the property

used for a primary personal residence by the applicant. Assets do not include the applicant's primary personal residence, personal family vehicles, or other personally owned items.

- Investments, banking or savings accounts that are not used for routine regular amounts of disbursements (income) are listed as assets. List these on the application in section VI and on line six (6) on the financial eligibility worksheet.
  - Please refer to the CSA **Financial** Accounts/**Assets Worksheet** for assistance with estimating the value of financial accounts that may be owned by the applicant and their family.
  - Do not include tax deferred investments held as IRAs, Roths or employer sponsored 401K accounts or similar pension savings accounts. These are not counted as assets for purposes of CSA eligibility determination.
- If the patient or family owns real estate property (dwelling or land) which is not currently rented and is not the primary residence of the applicant, the fair market value of the property will be counted as an **asset**. Fair market value must be documented by a printout of a web page from a site such as Home Gain http://www.homegain.com/homevalues or Zillow http://www.zillow.com/ which clearly displays the address of the property and the current estimated home value. In addition, tax and mortgage documents showing the home value, loan amount, remaining balance owed, and tax rate may be required to assist determination of the asset's value to be used in determination of Cancer State Aid eligibility.
  - Please refer to the CSA Real Estate/**Property Assets Worksheet** for assistance with estimating the value of properties that may be owned by the applicant and their family.
  - Real estate property that has been on the sales market for a long period of time (over 90-120 days) may at the discretion of CSA be excluded from asset calculations. Upon sale of any real estate property, updated financial forms will be required and a redetermination of the patient's financial eligibility will be conducted. The patient must notify the facility, who then must notify CSA of changes in assets or income.
- If an applicant or family has total assets that exceed one half of the *Annual Income Limit* for the applicant's family size, the applicant may not qualify for CSA even though the actual earned income may qualify.

◈ Section VII: Outstanding Family Medical Expenses

Outstanding medical expenses are the total amount of all outstanding medical bills owed out-of-pocket by the patient and/or qualified family member(s) counted in family size.

- If a patient is over-income for the CSA program, outstanding medical expenses may be used to establish eligibility.
- On the date outstanding expenses exceed one half of the Annual Income Limit for the family; the applicant may become financially eligible. The amount of the outstanding medical expenses used to decrease income to qualify for CSA cannot be paid by CSA. Payment of these expenses would remove the credits to income causing the patient to become ineligible for CSA. Outstanding medical expenses that exceed the amount used to help the patient qualify may be considered for payment based upon available funds.
- Outstanding medical expenses cannot be used to establish eligibility without documentation.
- If outstanding medical expenses are used to establish eligibility for a patient who would not otherwise be eligible, documentation must be submitted with the application.

- The provider/facility should also retain a copy of these expenses in the applicant's CSA financial information on file at the facility.

◈ **Section VIII: Agreement –** The patient must sign and date the application. If the patient makes a mark instead of a signature, the facility contact/reviewer must witness the signature.

- The patient must also initial the box on the lower left side of this section.

Initialing here confirms that they have been informed that:

"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 are not eligible for payment. The patient is responsible for payment of unapproved facilities & ineligible providers or services."

- The agreement clause serves the following purposes:
  - It is a binding statement signed by the patient verifying that the information provided is true and accurate.
  - It serves as a medical release to obtain medically necessary information about the patient.
  - It verifies that the patient has been provided a copy of the DCH privacy practices information
  - And it verifies that the patient has been informed of key program information.
- Should the provider reviewer be unable to determine *presumptive eligibility*, the reviewer should contact the CSA office for assistance.
- It is the responsibility of the participating CSA facilities to ensure that assigned staff completing applications has adequate training to fully complete applications, and to determine the likelihood of a patient's eligibility for the CSA program. Facilities should contact CSA to request needed training.

◈After completion of all sections on the applicant's Financial Application (form 3621F), the CSA Patient Contact/Coordinator or "reviewer" must then complete the accompanying **Worksheet for Financial Eligibility.** This completed worksheet is required with every application. If this is not submitted or is incomplete the application may be returned to the facility.

- Enter the amounts calculated for each item in Part I of the worksheet.
- Answer the questions in Part II of the worksheet. Answer A and B first, then if needed then answer questions C and D. These questions will tell you immediately whether or not the patient is eligible for CSA enrollment.
- If the worksheet determines that the patient is not eligible for CSA and you would like CSA to review the application and worksheets, please submit the application and supporting documentation to CSA for additional review and to confirmation.
- CSA will review the submitted information, make an enrollment eligibility determination. CSA will provide notification to the CSA Patient Contact at the facility and to the patient if the application is denied. If the application is approved, notification will be provided to CSA Patient Contact and the CSA Billing Contact at the facility, and to the patient.

◈**To submit a complete application packet to CSA, please include the following:**

Original copies of the (facilities are required to keep a copy of all materials for reference):

CSA Financial **Application** Form 3621F

The **Worksheet for Financial Eligibility** is required with every application.

1. **If** other worksheets are used to determine financial eligibility they also must be submitted:
   a. Financial Accounts/Assets **Worksheet**
   b. Real Estate/Property Assets **Worksheet**

   *Please **do not** submit these additional worksheets (a. and b. above) if the patient or their family members do not own these types of assets.
2. **Medical Eligibility Form** (form 3621D or 3621T) – include the pathology report, and physician notes or medical documentation of conditions suspicious for cancer that need a diagnostic workup.

   *Please refer to the Medical Eligibility Request Forms Guidance 2014 for full instructions.

   a. **If a patient is enrolled for diagnostic testing, and testing confirms cancer is present, a fully completed Form 3621T must be submitted to CSA for the planned course of treatment to be evaluated for program approval of funding of treatment.** Continuation of program enrollment for treatment once the diagnosis is completed must be evaluated and approved separately from the approval for diagnostic testing. The diagnosis, stage of disease and prognosis along with the planned course of treatment must be described, listed on the form and submitted to CSA**.**
   b. Approval of treatment services is not guaranteed for any patient already enrolled for payment of diagnostic, staging and treatment planning services. Consideration of payment eligibility for treatment is separate from approval for enrollment for diagnostic services.
   c. The Medical Eligibility Form 3621T may be faxed to CSA (404-657-6316).
   d. The confirmed diagnosis of cancer and prognosis for five year survival must meet CSA medical eligibility guidelines to be eligible for program enrollment and payment of treatment services.
   e. **Only prognoses of five year survival of 25% or greater based upon the patient's current health status, and current medical and scientific literature, are eligible for program funds.**
   f. If the cancer is not eligible for program enrollment, payment is made for the diagnostic services, staging and treatment plan workup, and program enrollment ends.
   g. If the facility does not submit the fully completed **Form 3621T** after the diagnostic, staging and treatment planning services are completed the patient's program enrollment will end. CSA payment will be made only for the approved medical services necessary to establish a diagnosis, stage and treatment plan.
   h. **No payments will be made** for treatment services provided without CSA approval of the patient's enrollment for funding of treatment services. This applies to all patients approved for enrollment based upon the need to establish a diagnosis, and/or staging and treatment planning.

3. Copies of all documents that confirm income and assets. Please see the Cancer State Aid Assets and Income Verification Guidelines.
4. Submit a copy of outstanding medical bills showing the total amount owed to each medical provider or facility only if medical bills are used as a credit to help a patient qualify for CSA that otherwise would not be eligible,.
5. If the patient would be eligible even without the outstanding medical bills, then list those amounts in Section VII of the application. In this situation, copies of the medical bills are not required.
6. If outstanding medical bills service dates fall within the requested approval date, the facility may submit claims for those expenses with the application, for payment consideration. Payments of existing cancer related medical bills are dependent upon available funding and are not guaranteed. Only dates of service falling with the CSA approval dates will be considered for payment. Requested start dates exceeding 60 days prior to the CSA receipt date of the application are unlikely to be approved.
7. Outstanding bills that cause the patient, who would not otherwise be eligible, to qualify for CSA enrollment are **not eligible** for program payment.

Final eligibility decisions are determined by CSA. Additional supporting information may be requested. A letter will be sent advising the patient of the eligibility decision. Decision letters may be mailed, faxed or sent by [secured email] to the facility's Patient and Claims/Billing Contacts. The patient and facility contacts should retain the letter for confirmation of each patient's CSA enrollment.

◈Incomplete applications:

The designated contact at the provider facility may be contacted by phone or secured email to request additional information to complete all items required for the application. Additionally, a letter of request may be sent to document the request if the information is not readily available.

- To **avoid termination** of the application process and denial of the application due to incomplete information, the facility must contact CSA to confirm they will submit the requested information upon receipt of the telephone, secured email or request letter from CSA.
- All applications that remain incomplete 30 days from the date of CSA receipt are subject to denial at the discretion of CSA.

◈CSA does not accept applications from any individual, medical provider, program or facility other than those "Participating Facilities" that have a current signed agreement or contract with the program.

- If an application is received from a source other than the provider/treatment facility for the patient, it will not be reviewed by CSA and will be sent to the provider facility for review, verification and re-submission to CSA or it may, at the discretion of CSA, be shredded.
- Applications received from a patient who has not been receiving cancer related services or is not yet affiliated with a CSA facility, will not be reviewed by CSA. The patient will be contacted and advised to contact a CSA facility to assist application and to make medical care arrangements. The application will either be shredded or sent to the CSA facility of the patient's choice.

PLEASE CONTACT CSA FOR ASSISTANCE