Patient is Eligible for CSA (check after completing form): **Yes** ☐ **No** ☐

Georgia Department of Public Health

FY2014 CANCER STATE AID PROGRAM REQUIRED WORKSHEET FOR FINANCIAL ELIGIBILITY

Must be fully completed by participating facility staff only, and submitted.

Patient Name: _____ **DOB:** ____ _____ _____

PART I: To select the number from the drop down list, arrow to the number and then click inside the field to save. Hover cursor over field to view description. Many fields will automatically calcuate totals.

1. **Qualified/eligible 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. (Enter number here that corresponds to the number of qualified individuals listed in Section IV of form 3621F.)

2. **Maximum qualifying monthly income** per family size: Scroll to income for family size and click on amount to select. $_ Click,Select You may also use the keyboard down arrow to scroll.

   Please refer to the current fiscal year Poverty Income for monthly income and enter the amount.

3. **Gross monthly family income**: $_

   Enter the verified Total Gross Family Monthly Income from Section IV of form 3621F.
   This is the amount before deductions, for all adult members over the age of 18 years, counted in family size.

4. **Credits to gross monthly family income**: Must be entered w/minus sign (-) $_____ ___

   Enter the Total Credits to Income amount from Section V of form 3621F.
   Credits are medical treatment expenses that occur monthly, including those not covered by other insurances or programs; does not include premiums for any family members' insurances.

5. **Net monthly income:** $_ $0

   Subtract the amount on line 4 (credits/expenses) from the amount on line 3 (gross family income). If Net monthly income is zero or less, enter zero on line 5. If there is no income, an explanation of how living expenses are being met must be included on form 3621F Section IV.

6. **Other resources/assets**: $_

   Enter the total amount from Section VI of form 3621F; **include totals from the Real Estate/ Property Assets worksheet and the Financial Accounts/Assets worksheet**. Assets include financial investment accounts, bank checking and savings accounts, and real estate (other than principle residence) and other family resources for members counted in family size.

7. **Outstanding medical expenses or bills owed**: $_____ ___ #8_Scroll to the amount closest to the Calculated Annual Income Limit dsiplayed to the left. Then click on the amount to select.
   Enter the total amount from Section VII of form 3621F.

8. **Annual income limit for family size**: Monthly Qualifying Inc x 12 mo = Calculated Annual Income Limit 0 $ Click, Select

   Please refer to the current fiscal year Poverty Income Guidelines and enter the maximum annual income amount for the applicant's qualified family size here.

   B. Divide the amount on line 8 in half and enter: $ 0 Line 8 muliplied by .5

Cancer State Aid Worksheet for Presumptive Financial Eligibility Determination

Part II

A) Is the amount on line 5 less than the amount on line 2?

Yes ☐ No ☐ Line 5= $0 Line 2 = $0

Is the family monthly net income (line 5) less than the maximum allowable monthly income (line 2) to qualify for CSA?

B) Is the amount on line 6 less than the amount on line 8B?

Yes ☐ No ☐ Line 6= $0 Line 8B= $0

Is the total amount of other family assets or resources (line 6) less than the six month family income limit (line 8B)?

*If both questions are checked "Yes" the patient qualifies financially for the Cancer State Aid Program.
Check "Yes" at the top of page one and sign the form. Skip questions C and D.

*If either questions A or B are checked "No", you must answer questions C and D to determine the patient's financial eligibility for CSA. Do not complete C, D if A, B determine the patient is eligible.

C) Is the amount on line 7 more than the amount on line 8b?

Yes ☐ No ☐ Line 7= $0 Line 8B= $0

Does the family have outstanding medical expenses (line 7) exceeding six months or half of the annual income limit for family size (line 8B)?

If "Yes", enter the date that line 7 exceeded line 8B: _____
This becomes the patient's eligibility date.

D) Is the amount on line 7 more than the amount on line 6?

Yes ☐ No ☐ Line 7= $0 Line 6= $0

Does the family have outstanding medical expenses (line 7) exceeding the amount of other family assets or resources (line 6)?

If the answer to BOTH questions C and D are "Yes", the patient DOES qualify financially for CSA.
Check "**Yes**" for eligibility at the top of page one and sign the form.

*If either C or D is answered "No", the patient does NOT qualify financially for CSA.
Check "**No**" for eligibility at the top of page one and sign the form.

Person completing form: _____ Title: _____
Signature

Date:

Provide contact information only if different from that listed in Section I on the application form 3621F.

Telephone: _____ FAX: _____

Provider Facility (site): _____