CHARLESTON
ONCOLOGY
Compassionate Care for Cancer
and Blood Disorders

Date: _____

Account #: _____

Request for Financial Assistance

Thank you for requesting information regarding our Financial Assistance program.

You must complete the instructions below in order for your application to be considered. **Failure to provide the below information may result in a denial.**

Instructions: Please send all information below if it applies.

- **Complete, sign and date the enclosed Financial Statement.**
- **Send a copy** of your current and **Complete 2021 Federal Income Tax Return**,
- **W-2 Forms** for the current tax year (if applicable).**If Single with NO Dependents**
- **Send the Current Year Social Security Benefits Letter** (if applicable).
- **Send proof of other Household Income;** for example, Alimony, Trusts, Annuities, Pensions, Retirement Benefits, Disability Income, Workers' Compensation Income, Unemployment Benefits, Student Loan Disbursements, Unreported income, etc.
- **If visiting the U.S**. from another country, **send proof of your current tourist, work, or student visa (green card).**

Please return the <u>fully completed application and required documentation</u> to Patient Financial Services via:

- **Fax @** 843-266-1981
  or
- **Mail to:** Charleston Oncology
  Attn: Patient Financial Services
  2085 Henry Tecklenburg, 2nd floor
  Charleston, SC 29414

or

- **Fax @** 843-628-1594
  or
- **Mail to:** Charleston Oncology
  Attn: Patient Financial Services
  2910 Tricom Street
  N. Charleston, SC 29406

In order to review all options available to you, we will need the above, required information returned to us within 30 calendar days. Please allow us 10-15 business days to review and process your application before calling for a status update.

If you have difficulty completing the attached form, please contact Charleston Oncology Patient Financial Services @ 843-577-6957, Monday through Friday, 9:00 am to 5:00 pm.

If this information is not received, the account balance(s) will remain billable to the responsible party. If you have any questions, please contact Charleston Oncology Patient Financial Services @ 843-577-6957, Monday through Friday, 9:00 am to 5:00 pm.

Sincerely,

Patient Financial Services
Charleston Oncology

CHARLESTON ONCOLOGY FINANCIAL STATEMENT Date: ____/____/____

The information requested is to determine if you qualify for financial assistance or a payment plan to satisfy your account(s) with Charleston Oncology. All information is strictly confidential for your protection.

Please complete all sections of the application. If a question is not applicable; use N/A for not applicable.

If this information is not received within 30 days from the date of this request, the account balance(s) will remain and be billable to the guarantor and/or responsibility party.

PATIENT INFORMATION

Name:	Home Telephone #:
Street Address:	Social Security #:
City, State, Zip:	Date of Birth:
Spouses Name (if applicable):	Spouse's Social Security #:

Check One:	Married ___	Single ___	Separated ___	Divorced ___	Widow/Widower ___	Life Partner ___

Are you a US Citizen or visiting the US legally?	Yes __	No ___	**If NO, you are not eligible for Financial Assistance.**

GUARANTOR / RESPONSIBLE PARTY INCOME INFORMATION

Name of Employer:	Employer Phone Number:
Address of Employer:	Social Security #:
City/State/Zip:	Date of Hire:
Total Number Living in Household _____	

Total Household Net Income:	$_____	Per (circle one):	Week	Every 2 Weeks	Month	Year
Other Household Income* (provide proof of income):	$_____	Per (circle one):	Week	Every 2 Weeks	Month	Year

Other Household Income includes: Part Time Job, Alimony/Child Support, Parental Support, Trusts, Annuities, Pensions, Retirement Benefits, Disability Income, Unemployment Benefits, Student Loans, etc.

Applicant	Co-Applicant	**LIST ALL ASSETS, LIABILITIES, AND EXPENSES BELOW.** *If you do not have any assets or liabilities, please write "NONE" in the space below.*			
		Assets or Possessions	**Description**	**Market Value/Worth**	**Monthly Payment Amount (if applicable)**
		Home			
		Automobile (year & model)			
		Automobile (year & model)			
		Boat			
		Stocks			
		C.D's			
		I.R.A.'s			
		Savings Account			
		Other Real Estate			
		Other Personal Property			
		Life Insurance Policy			
		Other			
		Other			

Applicant	Co-Applicant	LIST ALL EXPENSES BELOW.		
		Expense	**Creditor Name and Address**	**Monthly Payment**
		Credit Card(s)		
		Utilities (Power, Gas, Cable)		
		Groceries		
		Prescription Drugs		
		Dependent/Child Care		
		Health/Life Insurance		
		Taxes		
		Other		
		Other		

If you claim your income as $0.00, please provide information regarding your living situation and/or means of support below:

Do you file a Federal Income Tax Return?	Yes ___	No ___	# of Dependents claimed on Federal Tax Return	

Do you have any Health Insurance coverage not previously filed? (circle one) Yes or No
If yes, name of Insurance Company, Address, Phone Number and Policy Number:

Is insurance, attorney, or any other third party payment involved for any remaining Charleston Oncology account balances? (circle one) Yes or No

Please provide details:

I attest that this financial statement is true and correct to the best of my knowledge. I authorize Charleston Oncology to verify my employment, debts, and assets if deemed necessary. I understand that falsifying information may result in a denial of financial assistance.

_____ _____

Signature of Responsible Party (*Required*) **Date**