CAFA Overview

The information collected in this application is required in order to determine eligibility for Coverage Assistance and Financial Assistance (CAFA). CAFA is a financial assistance program for uninsured patients who have received services with AnMed Health Cannon Hospital and/or AnMed Health Cannon Physician Services. Eligibility is based on a patient's household income as compared to federal poverty guidelines.

Requirements to Apply for CAFA

- The patient must be uninsured.
- The patient must reside in South Carolina or Georgia.
- The patient must fully cooperate with determination of other coverage options including but not limited to Medicaid, Cobra, Workman's Compensation, Liability, etc. If additional information and/or proof of income, bank statements, etc. is requested, a letter will be mailed to the patient to let them know what is needed and the deadline to submit. If the information is not received by the deadline, the patient will not be eligible for CAFA.
- The patient must complete the CAFA application in its entirety.

Documents required to accompany the CAFA Application

Please send only copies as these will not be returned.

- Proof of last month's household income: Check stubs, unemployment letter, Award Letter from SSA.
- Bank statements for the last two months (checking and/or savings) for all bank accounts patient and spouse are listed on.
- If legally separated from your spouse, please provide proof of the legal separation.

Patient Information			
Patient Name	Social Security Number	Date of Birth	Account #
Mailing Address		City	State/Zip
Street Address if different than above		City	State/Zip
County you reside	Place of Birth	Legal resident/citizen : Yes or No	Lived in US since
Mother's Maiden Name	Phone	Email	

LIST ALL HOUSEHOLD MEMBERS

Name	Date of Birth	SSN	Relationship to Patient	Sex/Race
		_ _		
		_ _		
		_ _		
		_ _		
		_ _		
		_ _		

If additional space is needed please use the notes section of this application.

Current Employment	Pay Rate Hr/Wk	Job title	Date of Employment
Spouse's Employment	Pay Rate Hr/Wk	Job title	Date of Employment

If there is no household income, please have the person supporting you to complete this section.

This is to certify that I am/was providing the following type of support and assistance to the above named applicant: ☐ Food ☐ Shelter ☐ Cash Amount per month: $______________
I am not responsible, nor able to pay for any hospital or medical expenses for him/her.

Signature ____ Phone Number _______________________________________ Date ________________________________

Address if different from above: ____ City _____________________________ State ______________ Zip __________________

Has a member of the household lost their job within the last 60 days?	Check one	☐ YES	☐ NO
Did he/she receive a COBRA election Notice?	Check one	☐ YES	☐ NO
Did he/she receive a COBRA election Notice?	Check one	☐ YES	☐ NO
Did he/she elect COBRA coverage?	Check one	☐ YES	☐ NO
Have you or do you plan to apply for disability with Social Security Administration?	Check one	☐ YES Date _______	☐ NO
Are you pregnant? ☐ YES ☐ NO	Were you in foster care in SC at the age 18 or older?	☐ YES	☐ NO

Monthly Household Income

Type of income	Monthly Gross Income for Applicant	Monthly Gross Income for Spouse
Employment Income	$	$
Retirement/Pension	$	$
Social Security Retirement	$	$
Social Security Disability Income	$	$
Unemployment Income	$	$
Child Support	$	$
Alimony	$	$
Other (list source here ___________________)	$	$

Acknowledgement and Signatures

I hereby certify the information provided in this CAFA application is true, accurate and complete to be best of my knowledge. I hereby authorize AnMed Health Cannon to contact any person, firm, or organization to verify any of the information given and I hereby authorize any such person, firm, or organization to release to AnMed Health Cannon any financial information it may request. If the hospital believes that I may be eligible for coverage, I agree to cooperate with the facility's efforts in obtaining benefits.

Applicant Signature Date

Notes

How to submit application: Hand deliver to:

AnMed Health Cannon
Attention: Financial Counselor
123 W.G. Acker Dr
Pickens, SC 29671

Mail to:

AnMed Health Cannon
Attention: Financial Counselor
123 W.G. Acker Dr.
Pickens, SC 29671