



Coverage Assistance & Financial Assistance

CAFA Overview

The information collected in this application is required in order to determine eligibility for Coverage Assistance and Financial Assistance (CAFA). Eligibility is based on a patient’s household income as compared to federal poverty guidelines.

Requirements to Apply for CAFA

- 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 the items will NOT be returned.

- Proof of last month’s household income: Check stubs, unemployment letter, Award letter from SSA, etc.
- Bank statements for the last two (2) months (checking and/or savings) for all bank accounts patient and/or spouse are listed on.
- If legally separated from your spouse, please provide proof of separation.

Patient Information:			
Patient Name:	Social Security Number:	Date of Birth:	MRN:
Mailing Address:		City:	State/Zip:
Street Address (if different than above):		City:	State/Zip:
County of residence:	Place of Birth:	Legal Resident / Citizen:	Lived in US since:
Mother’s Maiden Name:	Phone #:	Email:	

LIST ALL HOUSEHOLD MEMBERS:

Name:	Date of Birth:	Social Security Number:	Relationship to Patient:	Sex:	Race:

If additional space is needed, please use the notes section on page 2 of this application.

Current Employment:	Pay Rate:	Hrs / Wk:	Job Title:	Date of Employment:
Spouse’s Employment:	Pay Rate:	Hrs / Wk:	Job Title:	Date of Employment:

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

This is to certify that I am / was providing the following type(s) of support and assistance to the above-named applicant: (check all that apply) Food Shelter Cash \$ _____ per month. I am not responsible nor able to pay for any hospital or medical expenses for him/her.

Signature: _____ Phone #: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

**South Carolina Department of Health and Human Services (SCDHHS)
Eligibility, Enrollment and Member Services
Toll-free (888) 549-0820 (TTY 1-888-842-3620)**

Authorization to Disclose Health Information

For Office Use Only – TO BE COMPLETED BY SCDHHS

Applicant/Beneficiary Name		
<i>(First)</i>	<i>(Middle)</i>	<i>(Last)</i>
Social Security No.	Date of Birth	Household No./App ID

**** PLEASE READ BOTH PAGES OF THIS FORM BEFORE SIGNING BELOW.****

I voluntarily authorize and request disclosure (including written, verbal, and electronic interchange) of:

WHAT: *All my medical records, education records and other information related to my ability to perform tasks.
This includes specific permission to release the following*

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, but not limited to:
 - Psychological, psychiatric or other mental impairment(s) (excludes “psychotherapy notes” as defined in 45 CFR 164.501)
 - Drug abuse, alcoholism, or other substance abuse
 - Sickle cell anemia
 - Human Immunodeficiency Virus (HIV) infection, including Acquired ImmunoDeficiency Syndrome (AIDS) or tests for HIV or sexually-transmitted diseases
 - Gene-related impairments, including genetic test results
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affects my ability to work
3. Copies of education tests or evaluation, including individualized educational programs, triennial assessments, psychological and speech evaluations, teacher observations and evaluations, and any other records that can help evaluate function
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM:

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.), including mental health, correctional, and addiction treatment and VA health care facilities
- All educational sources (schools, teacher records, administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SCDHHS AND AGENCIES AUTHORIZED BY SCDHHS TO ASSIST WITH DISABILITY DETERMINATION PROCESSING (as needed) for additional information to identify the subject (e.g., other names used), the specific source, or the material to be used.

TO WHOM: The agency authorized by SCDHHS to process my case including contract copy services, doctors, or other professionals consulted during the disability determination process.

PURPOSE: I agree to disclosure of my health information to determine if I meet the disability criteria in order to establish my eligibility for Medicaid benefits.

EXPIRES WHEN: This authorization is binding for 12 months from the date signed below.

I UNDERSTAND THAT:

- I may write to the South Carolina Department of Health and Human Services to revoke this authorization at any time.
- There are some circumstances where the information may be re-disclosed to other parties involved with the Medicaid eligibility determination.
- I may receive a copy of this form upon request.
- I may ask the source to allow me to inspect or get a copy of the material to be disclosed.

Applicant Signature (Person Applying for Benefits OR Parent/Guardian if Applicant is Under Age 18):	Relationship to Applicant: SELF
Legal Representative Signature (if Applicant is Unable to Sign Due to Health):	Date:
Child Signature (Required if Applicant is Age 12 to 18):	<input type="checkbox"/> Power of Attorney or legal guardian documentation is attached if signed by a Legal Representative.
Witness:	Witness if signed with an “X”

INFORMATION RELEASE FORM

I hereby authorize the South Carolina Department of Health and Human Services to verify my income including but not limited to Social Security, Supplemental Security Income, Veterans Benefits, private pensions, earned income, etc.; my resources including but not limited to checking and savings accounts, certificates of deposit, individual retirement accounts, credit union accounts, etc.; insurance, medical history, and expenses; and any other facts relevant to my eligibility for participation in programs administered by the Department of Health and Human Services.

I also authorize any person, partnership, corporation, association, or governmental agency possessing information on such matters to release such information to the Department of Health and Human Services.

I certify that I have read the above statement and understand that this gives my permission for release of such information.

Print your name: _____

Signature: _____

Address: _____

Witnesses to Signature (if signed by an X): 1. _____

2. _____

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. (*Signifies a required field. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form.)

TO: Social Security Administration

*Full Name	*Date of Birth (MM/DD/YYYY)	*Full Social Security Number
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I authorize the Social Security Administration to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION: ANMED FINANCIAL COUNSELOR ANMED PATIENT RESOURCE COORDINATOR	*ADDRESS OF PERSON OR ORGANIZATION: ** PHONE NUMBER OF PERSON OR ORGANIZATION: 800 NORTH FANT ST. (ADMITTING DEPT.) 2000 E GREENVILLE ST. (CANCER SUPPORT SERVICES) ANDERSON, SC 29621
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***I want this information released because:** ASSISTING WITH DISABILITY AND MEDICAID PROCESS(ES)

We may charge a fee to release information for non-program purposes.

PLEASE DISCLOSE MY INFORMATION TO ANMED HOSPITAL ON AN ONGOING BASIS. I INTEND FOR THIS RELEASE FORM TO BE VALID FOR AN INDEFINITE PERIOD OF TIME.

***Please release the following information selected from the list below:**

Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. Verification of Social Security Number
2. Current monthly Social Security benefit amount
3. Current monthly Supplemental Security Income payment amount
4. Social Security benefit amounts from date _____ to date _____
5. Supplemental Security Income payment amounts from date _____ to date _____
6. Medicare entitlement from date _____ to date _____
7. Medical records from date _____ to date _____
8. Complete medical records
9. Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)
INFORMATION FROM ANY TITLE II OR TITLE XVI APPLICATION PENDING ON AN APPEAL, INCLUDING BUT NOT LIMITED TO APPLICATION STATUS.

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to \$5,000.

*Signature: _____ *Date: _____

**Address: _____ **Daytime Phone: _____

**Relationship (if not the subject of the record): _____ **Daytime Phone: _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of witness	2. Signature of witness
Address (Number and street, City, State, and ZIP Code)	Address (Number and street, City, State, and ZIP Code)

**APPOINTMENT OF PERSONAL REPRESENTATIVE AND
AUTHORIZATION FOR RELEASE OF INFORMATION**

This is to certify that I, the undersigned, have applied or wish to apply for Medical Assistance benefits for and on behalf of myself or (Patient): _____, I hereby appoint ANY AnMed Financial Counselor, Oncology Patient Resource Coordinator, or his/her successor on the Financial Counseling staff of AnMed, as my agent and personal representative and as the agent and personal representative of the Patient for the purpose of initiating applications for such benefits and/or conducting any and all activities associated with determining eligibility for such benefits, including, if required, the initiation and conduct of administrative and/or judicial appeals procedures concerning eligibility for such benefits. I also authorize the Hospital to use its own personnel and, at its own expense, to obtain legal consultation and representation to evaluate and pursue activities related to a determination of my or the Patient's entitlement to Medical Assistance benefits. This appointment and authorization shall also be valid for purposes of the AnMed Coverage Assistance & Financial Assistance benefits (CAFA) and any Hospital charity program for which I or the Patient may apply.

Furthermore, I hereby request and authorize the appropriate County Department of Social Services where any such application is to be made or is pending, and the South Carolina Department of Health and Human Services to accept this appointment of my personal representative and agent with respect to any application for such benefits and to accept from and release to said personal representative or counsel (or other representative of the Financial Counseling staff of AnMed) any and all information related in any way to any application and determination of eligibility for such benefits. I specifically request that copies of all notices about or requests for information related to eligibility for such benefits be provided to my personal representative at (864) 512-3435 or by mail addressed to the attention of such personal representative at AnMed, Financial Counseling Department, 800 N. Fant Street, Anderson, SC 29621.

Furthermore, I hereby authorize and direct any other person, firm, corporation, government agency, or other entity (specifically including but not limited to the Social Security Administration, all physicians, hospitals, banks, credit unions and insurance companies) who has or may have information from records or services rendered prior or subsequent to the execution of this authorization (specifically including but not limited to my identifiable health information concerning medical treatment and/or health status, insurance coverage of any type, eligibility for any benefits under the Federal Social Security Act, or financial information of any type) that is or may be relevant to the determination of eligibility for such benefits to release such information to the said personal representative as he or she may request. I UNDERSTAND THAT INFORMATION TO BE RELEASED MAY INCLUDE INFORMATION REGARDING DRUG OR ALCOHOL ABUSE, SICKLE CELL ANEMIA, PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENTS, SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), AIDS RELATED COMPLEX (ARC), HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND/OR GENE-RELATED IMPAIRMENT OR GENETIC TESTING RESULTS.

This consent may be revoked by me at any time by written notice to the Financial Counselor at the address shown above, except to the extent that action has already been taken in reliance on this consent. Unless so revoked, this consent shall be valid for the longer of three hundred sixty-five (365) days from the date indicated below, or until my Medicaid eligibility is finally determined and the time for appeals has lapsed. I specifically waive any lesser time periods or restrictions required by any entity from whom information is requested as set out above.

The purpose of disclosure is to review these materials in connection with Medicaid, CAFA, or other health benefit eligibility and/or coverage. The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary.

I further request that a photocopy or telefacsimile of this signed appointment and authorization be accepted and honored as if it were an original. This appointment of personal representative is made pursuant to applicable state and federal law including but not limited to 42 C.F.R. §431.200 et seq., 42 C.F.R. §435.907 and §435.908, S.C. Code Regs. §§ 114-410, 126-380, and South Carolina Medicaid Manual §1.02.02.

Date

Signature

Witness

Typed or Printed Name

Witness

(Witnesses (2) required if signature is by mark.)