Financial Assistance Application

To help us evaluate your eligibility for financial assistance, we recommend that you contact the Family Health Coverage Program at 267-426-0359 (toll-free at 1-800-974-2125) **before** submitting this application. Failure to provide accurate and complete information on this form, or to provide the required documentation, may affect your eligibility for financial assistance.

Patient Name: _____Date of Birth_____

Patient Address: _____

City: _____ State: _____ Country _____ Zip Code/Postal Code: _____

Social Security #: _____ Account #: _____ Service Date: _____

Guarantor Name: _____

Guarantor Address: _____

Guarantor Telephone #: _____

# of Family Members in Household: _____ How long at current address: _____ Yrs. _____Months

INCOME INFORMATION (PER MONTH)

Please provide the following information for adult(s) living in your household. Attach additional pages, if necessary. If any category does not apply, please write "N/A."

1. **Name: _____** **Relationship to patient: _____**

   Employer: _____ Hours worked per week: _____

   How often is the paycheck received: _____ Wage earnings per month: _____

   Social Security: _____ Disability: _____

   Retirement/Pension: _____ Child Support: _____

   Alimony: _____ Public Assistance: _____

   Unemployment: _____ Other: _____

2. **Name: _____** **Relationship to patient: _____**

   Employer: _____ Hours worked per week: _____

   How often is the paycheck received: _____ Wage earnings per month: _____

   Social Security: _____ Disability: _____

   Retirement/Pension: _____ Child Support: _____

   Alimony: _____ Public Assistance: _____

   Unemployment: _____ Other: _____

TOTAL MONTHLY INCOME (total sum of all monthly income sources indicated above): $ _____

HOUSEHOLD EXPENSES (PER MONTH)

Please fill in the blanks below to tell us about your household expenses. If any category does not apply, please write "N/A."

Mortgage: _____ Rent: _____ Utilities: _____

Food: _____ Medical Bills: _____ Insurance (health/life): _____

Credit Card: _____ Car Payment: _____ Car Insurance: _____

Child/Adult Care Expenses: _____

TOTAL MONTHLY EXPENSES: (total sum of all monthly expenses indicated above): $ _____

Other Financial Circumstances (optional): _____

_____

AVAILABLE ASSESTS

Please fill in the blanks below to tell us about your available assets. If any category does not apply, please write "N/A."

Bank/Financial Institution Name: _____

Current Savings Balance: _____ Current Checking Balance: _____

Current Balance in any other accounts maintained: _____

Investments (describe): _____

Other personal property: _____

TOTAL VALUE OF ASSETS (total sum of all asset information indicated above): $ _____

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I CERTIFY THAT THE INFORMATION SET FORTH IN THIS FINANCIAL ASSISTANCE APPLICATION, INCLUDING ANY ATTACHMENTS, IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

I certify that, based on my income, available assets and other financial circumstances, I am unable to satisfy my financial obligation for services rendered by The Children's Hospital of Philadelphia or one its affiliates. I understand that the statements I have made on this form are subject to investigation and verification. I understand that I will be asked to provide proof of the Income Information I have given on this form, and I agree to assist The Children's Hospital of Philadelphia to obtain the necessary verification. I hereby authorize the release of the information that I have provided to the state Medicaid agencies and Medicaid managed care organizations. I further agree to immediately notify The Children's Hospital of Philadelphia if any of the information on this form changes in any significant way during the next year.

_____ _____

Signature Printed Name

_____ _____

Relationship to patient Date

_____ _____

Guarantor Signature Date