Application for Charity Care and Financial Assistance - Please Print

Personal Information

Patient's Name: ____

Print name of parent or other responsible party: ____________________________________

Mailing Address: ____

____

Telephone Number: Work (_____)_________________ **Home** (_____)_________________

Number of people in family (living in household): ________

Health Insurance information

Medical Insurance Yes ______ **No**_______ **If "yes," print name of insurance company:**

____

Policy Number: ____

Please identify any other coverage:

Medicare _____ **Medicaid** _____ **Other**___________________________

Is the medical treatment because of an accident or other third party injury?

Yes _____ **No**______

Please describe the accident ____

Is the medical treatment because of an on-the-job injury or accident?

Yes _____ **No** ______

Employer's Name and Address____

____

Income/Dependent Verification: Documented proof of income and number of claimed dependents must be included with this application. Please include the following documents with your application.

- **last year's income tax return <u>and</u>**
- **pay stubs from all current employment; or "W-2" withholding statement(s);**

Other sources of information that may be required to approve an application for uncompensated care are:

- **letters approving or denying Medicaid, medical assistance, other benefits; or**
- **letters approving or denying unemployment compensation; or**
- **written statements from employers or welfare agents; or**
- **a letter that is signed and notarized indicating financial support.**

If any of these items are available, please also request these be included with the application.

Application for Charity Care and Financial Assistance – continued

Current family monthly income (before taxes are taken out): $_________________

Will your family have a decrease in income, due to job loss, layoffs, reduced work hours or similar situations in the immediate future (within the next month)?

Yes ____ No ____ If yes, please describe:

____

____

Will your family have an increase in income, in the immediate future (within the next month)?

Yes ____ No ____ If yes, please describe:

____

____

Have you recently suffered severe financial hardship or personal loss (for example, other medical expenses, loss of home due to fire)?

Yes ____ No _____ If yes, please explain:

____

____

If you are asking for Charity Care for services already provided by CHKD, please list date(s) of services and what services you received:

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I understand that the information I am giving will be subject to verification and can be reported to state and/or federal enforcement agencies and others as required by law. I certify that the above information is true and accurate to the best of my knowledge and that I am applying for Charity Care at Children's Hospital of The King's Daughters.

Applicant's Signature ____

Date: ___________________

Please return this application with all documentation to:

Children's Hospital of The King's Daughters
Patient Financial Services / HBA
601 Children's Lane
Norfolk VA 23507
Email: charitycare@chkd.org