Children's Hospital of The King's Daughters

Application for Uncompensated Care - Please Print

Personal Information

Patient's Name: ____

Print name of parent or other responsible party:

____

Mailing Address: ____

____

Telephone Numbers: Work (   ) ______________ Home (   ) ______________ Cell (   ) ______________

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 including the date and time of injury: ______________________

____

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; (REQUIRED)**
- **pay stubs from all current employment; or "W-2" withholding statement(s);**

Other sources of information that may be required to approve your 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 include these with your application.

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

Family Size **___________________**

Family Size greater than one should include only persons related by birth, marriage or adoption who reside together. Students under age 25, regardless of residence, who are supported by parents or others related by birth, marriage or adoption are considered to be residing with those who support them.

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: ____

____

Has your family had an increase in income within the last 12 months or will they 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: ____

____

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 Uncompensated Care with 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
Healthy You Program
601 Children's Lane
Norfolk, VA 23507