

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