Reset

Children's Hospital of The King's Daughters Health System

APPLICATION FOR CHARITY CARE AND FINANCIAL ASSISTANCE (Page 1 of 2) **PLEASE PRINT**

Patient #1: _____ Date of Birth: _____

Patient #2: _____ Date of Birth: _____

Patient #3: _____ Date of Birth: _____

Parent, Guardian, or Other Responsible Party: _____

Mailing Address: _____

_____

Phone #s: (C)_____ (W) _____(H) _____

Number of people in family (living in household): _____
Number of exemptions claimed on your tax return: _____

HEALTH INSURANCE INFORMATION ***Optima Health Plan and Tricare enrollees are not eligible***

Medical Insurance: ☐ Yes ☐ No

Type of Insurance: _____

Policy and/or ID Number: _____

Is this medical treatment due to an accident, on-the-job injury, or other third party injury? ☐ Yes ☐ No

Briefly describe the accident or injury: _____

Employer's Name and Address: _____

_____

HOUSEHOLD INCOME

ALL sources of household income must be verified.

Attach the following documents with your application (all that may apply):

- Last year's Federal Income Tax Return (IRS Form 1040) or W2s or Paystubs (last 2 months)
- Child support (DCSE Disbursements, Direct Deposit Statements, or Written Statement from Absent Parent)
- Unemployment Compensation (VEC Monetary Determination)
- Social Security/SSI (Award Letters)
- Veterans Benefits (Award Letters)

Other Documents Needed:

- Medicaid/FAMIS and other benefits Approval or Denial Letters
- If you are claiming NO INCOME, you must provide a signed and notarized letter indicating financial support.

APPLICATION FOR CHARITY CARE AND FINANCIAL ASSISTANCE (Page 2 of 2) **PLEASE PRINT**

Current Monthly GROSS Income (amount of income before any taxes or other deductions 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 of personal loss (Example: Other medical expenses or loss of home due to a fire, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

_____

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

_____

Charity Care is limited to residents of the region (portions of Virginia or North Carolina) who have valid legal presence in the United States. *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, by my signature, 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 Application with all Documentation to:

Children's Hospital of The King's Daughters
Patient Financial Services – HBA
601 Children's Lane
Norfolk, VA 23507
Phone: 757.668.7141
Email: charitycare@chkd.org
FAX: 757.668.9181