UTAH DEPARTMENT OF HEALTH

Children with Special Health Care Needs
(CSHCN)
FINANCIAL FORM
For CHAP

********** Required Information **********

Child's Name:	DOB:

Primary Insurance Name:	Primary Insurance ID #:
Primary Policy Holder's Name:	Primary Insurance Group #:

Secondary Insurance Name:	Secondary Insurance ID #:
Secondary Policy Holder's Name:	Secondary Insurance Group #:

Is patient receiving SSI (Supplemental Security Income)? □ Yes □ No

To help us determine your eligibility for the **Children's Hearing Aid Program (CHAP)**, please complete the following information.

☐ I decline to fill out the section below. I understand that by withholding the information below, my child will not be eligible for CHAP.

Number of Children (If pregnant, include the unborn child)	_____
Number of Adults (Including yourself, spouse and any eligible adults)	_____

→ **Total Family Size**

MONTHLY Gross Income for Family

MONTHLY Gross salary (primary wage earner): Before Taxes, Social Security, Insurance Premiums, Union Dues	$ _____
MONTHLY Gross salary (other wage earner(s)):	$ _____
Other MONTHLY income: Includes pensions, compensations, income from rentals, interest, dividends, alimony or child support, public assistance grants, etc. ***SSI income is NOT included as income***	$ _____
Total Monthly Gross Income*	$ _____

MONTHLY Expenses for Family (Out of pocket)

Medical/Dental Expenses	$ _____
Medical/Dental Premiums	$ _____
Child Support or Alimony	$ _____
Child Day Care Costs	$ _____
Total Monthly Expenses**	$ _____

Shaded area for agency use only				*Notes:*
Total Yearly Gross Income*	$ _____	**CHAP Eligible?**	Y N	
Total Yearly Expenses**	$ _____			
Total Net Income (Annual)	$ _____			

I understand that my child's eligibility for CHAP will be calculated based on the information I provided above.

_____ _____
Print Name of Patient or Legal Representative Date

_____
Signature of Patient or Legal Representative

□ Parent of minor child □ Legal Representative
□ Medical Power of Attorney
□ Other, explain and attach documentation
_____

_____ _____
Signature of CHAP Representative Date