UTAH DEPARTMENT OF HEALTH

Children with Special Health Care Needs (CSHCN)

FINANCIAL FORM For CHAP

Reset Form

********** 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)	**Total Family Size**
Number of Adults (Including yourself, spouse and any eligible adults)	

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?**	◯ Yes ◯ No	
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		☐ Parent of Minor Child
Signature of Patient or Legal Representative	Date	☐ Legal Representative
		☐ Medical Power of Attorney
Signature of CHAP Representative	Date	☐ Other, Explain, attach documentation