## Personal Financial Form (PFR)

**CSHCN**

### Required Information

**Personal Financial Form (PFR)**

**Rev. 12/09/2014**

**Note:** A new form is required annually or any time there is a change in family size or income. When completing this form for the Kurt Oscarson Children’s Organ Transplant Fund, all sections (A, B, and C) must be completed.

### A. Patient Information

- **Patient Name:**
- **DOB:**

### B. Financial Assistance Available

You may be eligible for financial assistance for services provided by Children with Special Health Care Needs. To help us determine your eligibility for assistance, please complete the following information, and provide your last three consecutive pay check stubs, or most recent IRS tax return (front page is sufficient).

- I decline to fill out the section below. I understand that by withholding this information, I will not be eligible for financial assistance for services provided and may be liable for all or a portion of the bill.

#### Number of Children

- (If pregnant, include the unborn child)

#### 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**

- $_________

### Personal Financial Responsibility (PFR)

- 0% 20% 40% 60% 100%

### Y N

### Shaded area for agency use only

- **Total Monthly Gross Income**
  - $_________

- **Total Monthly Expenses**
  - $_________

- **Total Net Income**
  - $_________

### C. Signature Information

- I understand that my Financial Responsibility will be calculated based on the information I provided above. I understand that I may be liable for all or a portion of the bill and that interest may be charged on accounts unpaid 60 days after billing date.

- **Print Name of Patient or Legal Representative:**
- **Date:**

- **Signature of Patient or Legal Representative:**

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

- **Name of CSHCN Representative and Date (Please Print):**

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### Allowable Medical Expenses

Qualifying expenses must be directly related to the health or medical condition of a family member. Expenses must be out of pocket for the previous 12 months and for which you will not be reimbursed by a third party payor.

- Capital expenses for equipment or improvements to your home needed for medical care
- Cost and care of guide animals aiding the blind, deaf, and disabled
- Cost of lead based paint removal
- Expenses of an organ transplant
- Hospital services fees (lab work, therapy, etc.)
- Birth control pills, legal abortion, legal operations
- Meals and lodging provided by a hospital during medical treatment
- Medical and hospital insurance premiums
- Medical services fees (from doctors, dentists, surgeons, specialists and other medical practitioners)
- Oxygen equipment and oxygen
- Prescriptions, medicines, and insulin
- Tutoring recommended by a doctor
- Psychiatric care at a specialty equipped medical center (includes meals and lodging)
- Special items (hearing aids, wheelchairs, etc.)
- Special school, tuition, meals and lodging
- Transportation for medical care
- Treatment at a drug or alcohol center
- Wages for nursing services
- Diaper costs related to medical problem

### What cannot be included as expenses:

- Diaper services
- Health club dues
- Household help
- Stop smoking program
- Weight loss program
- Life insurance or income protection policies
- Maternity clothes
- Medicine bought without a prescription
- Nursing care for a healthy baby
- Surgery for purely cosmetic reasons