

A	Patient 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 #:

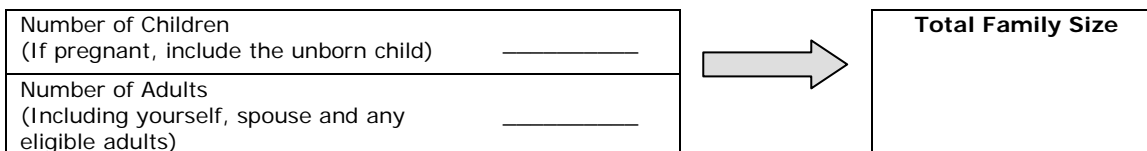
**Is patient receiving SSI (Supplemental Security Income)?**       Yes     No

**Is patient receiving Medicaid, CHIP, or FEP/TANF?**       Yes     No      **If "Yes", skip to Section C below.**

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.**



**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. <b>SSI income is NOT included as income</b>	\$ _____
<b>Total Monthly Gross Income*</b>	<b>\$ _____</b>

**MONTHLY Expenses for Family (Out of pocket)**

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

*Shaded area for agency use only*

Total Monthly Gross Income*	\$ _____	<b>Personal Financial Responsibility (PFR)</b>	0% 20% 40% 60% 100%	Y	N
Total Monthly Expenses**	\$ _____				
<b>Total Net Income</b>	<b>\$ _____</b>				

C

**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       Self (18 or older)  
 Medical Power of Attorney       Legal Representative  
 Other, explain and attach documentation

Name of CSHCN Representative and Date (Please Print) \_\_\_\_\_

## CSHCN Financial Form Worksheet References

<b>Allowable Medical Expenses</b>		
<p>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.</p>		
<ul style="list-style-type: none"> <li>• Capital expenses for equipment or improvements to your home needed for medical care</li> <li>• Cost and care of guide animals aiding the blind, deaf, and disabled</li> <li>• Cost of lead based paint removal</li> <li>• Expenses of an organ transplant</li> <li>• Hospital services fees (lab work, therapy, etc.)</li> <li>• Birth control pills, legal abortion, legal operations</li> <li>• Meals and lodging provided by a hospital during medical treatment</li> <li>• Medical and hospital insurance premiums</li> <li>• Medical services fees (from doctors, dentists, surgeons, specialists and other medical practitioners)</li> </ul>	<ul style="list-style-type: none"> <li>• Oxygen equipment and oxygen</li> <li>• Prescriptions, medicines, and insulin</li> <li>• Tutoring recommended by a doctor</li> <li>• Psychiatric care at a specialty equipped medical center (includes meals and lodging)</li> <li>• Special items (hearing aids, wheelchairs, etc.)</li> <li>• Special school, tuition, meals and lodging</li> <li>• Transportation for medical care</li> <li>• Treatment at a drug or alcohol center</li> <li>• Wages for nursing services</li> <li>• Diaper costs related to medical problem</li> </ul>	
<b>What cannot be included as expenses:</b>		
<ul style="list-style-type: none"> <li>• Diaper services</li> <li>• Health club dues</li> <li>• Household help</li> <li>• Stop smoking program</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss program</li> <li>• Life insurance or income protection policies</li> <li>• Maternity clothes</li> <li>• Medicine bought without a prescription</li> </ul>	<ul style="list-style-type: none"> <li>• Nursing care for a healthy baby</li> <li>• Surgery for purely cosmetic reasons</li> </ul>