

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

A	Patient Name:	DOB:
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Primary Insurance Name:	Primary Insurance ID #:
Primary Policy Holder's Name:	Primary Insurance Group #:

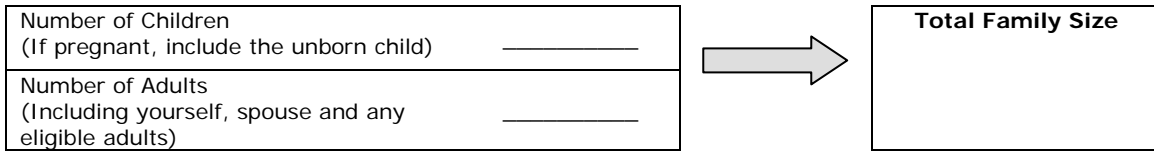
Secondary Insurance Name:	Secondary Insurance ID #:
Secondary Policy Holder's Name:	Secondary Insurance Group #:

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. 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**	\$ _____

<i>Shaded area for agency use only</i>			
Total Monthly Gross Income*	\$ _____	Personal Financial Responsibility (PFR)	0% 20% 40% 60% 100% Y N
Total Monthly Expenses**	\$ _____		
Total Net Income	\$ _____		

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

Allowable Medical Expenses		
<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"> • 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) 	<ul style="list-style-type: none"> • 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:		
<ul style="list-style-type: none"> • Diaper services • Health club dues • Household help • Stop smoking program 	<ul style="list-style-type: none"> • Weight loss program • Life insurance or income protection policies • Maternity clothes • Medicine bought without a prescription 	<ul style="list-style-type: none"> • Nursing care for a healthy baby • Surgery for purely cosmetic reasons