UTAH DEPARTMENT OF HEALTH
Children with Special Health Care Needs

Personal Financial Form (PFR)

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.**

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

Total Monthly Gross Income* $ _____ Total Monthly Expenses** $ _____ **Total Net Income** $ _____	**P**ersonal **F**inancial **R**esponsibility (PFR)	0% 20% 40% 60% 100%	Y N

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)

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

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.

CSHCN Financial Form Worksheet References

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

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