Children's National

Children's National
Financial Assistance Application

Children's National will offer financial assistance to patients who are unable to pay their hospital and/or clinic bills due to difficult financial situations regardless of age, gender, race, creed, disability, social or immigrant status, sexual orientation, or religious affiliation. A Children's National Financial Counselor, designated business office representative, or committee with authority to offer financial assistance will review individual cases and make a determination of financial assistance that may be offered.

Medically necessary care is considered medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health related illness, condition or disability including services necessary to prevent a detrimental change in either medical, behavioral, mental, or dental health status.

Eligibility for financial assistance will be considered for individuals who are uninsured, underinsured, ineligible for any government health care benefit program, or unable to pay for their care. Patients whose family income is at or below 400% of the federal poverty level and who have resided in our primary service area (PSA) for at least 6 months are eligible for full financial assistance. This policy only covers patients that do not reside in our PSA when the hospital is required to stabilize the medical condition of the patient before discharge.

Financial need will be determined in accordance with procedures that involve verifying income and residency in our PSA. The patient or the patient's guarantor will be required to cooperate and complete the FAP Application and provide the following:

1. Please provide your 1040 income tax return for the past 2 years.

2. A valid current form of identification for the patient, parents, or guardian. This can include a passport, alien registration card, work authorization, or any picture ID with the full name and complete address printed on it.

3. Proof of address – This can include a copy of your lease, mortgage statement or a notarized letter from your landlord.

4. If applicable, school verification or report card for patient.

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Children's National shall determine whether or not patients are eligible to receive financial assistance for deductibles, co-insurance, or co-payment responsibilities. Children's National will make reasonable efforts to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs. Children's National may make inquiries to obtain reports from third parties such as credit agencies, on certain patients to determine whether they may be presumptively eligible (presumptive eligibility) for financial assistance to relieve the financial burden.

Financial assistance will be denied for patients that submit an incomplete application, or submit documents that cannot be verified. Approved charity applications will expire 6 months from the approval date. At that time, patients will need to re-apply for continued financial assistance by contacting the Financial Information Center.

Call the Financial Information Center at 800-787-0021 option 6 if you need assistance in completing the application or have any questions about the review process. Mail your completed application along with all the required documents to Children's National 111 Michigan Avenue (FIC room 1820) Washington, DC 20010.

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CHILDREN'S HOSPITAL
Financial Screening Application Form

In order that we can assist you in a timely and efficient manner, please follow these instructions for completion of the application form.

1. Please Print or Type all requested information.

2. Please Sign and Date the application when completed (both parents must sign if both are in the home).

PATIENT INFORMATION: Please list below those children for whom you are requesting assistance.

Last Name	First Name	DOB	Male / Female

OTHER DEPENDANTS: Please list below any other dependents (other than the children listed above or the parents listed on the next page) residing in your household.

Last Name	First Name	DOB	Male / Female

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PARENT/GUARDIAN INFORMATION: Please complete for both parents/guardians:

Patient/Parent/ Guardian Last Name:		First Name:	
Age:	Social Security Number:	Relationship to Child(ren):	
Home Address:	City:	State:	Zip Code:
Home Phone:		Work Phone:	
Employer Name:		Address:	
How Long Employed?:		Occupation:	
Second Parent/Guardian/Spouse Last Name:		First Name:	
Age:	Social Security Number:	Relationship to Child(ren):	
Home Address (if different from above):	City:	State:	Zip Code:
Home Phone:		Work Phone:	
Employer Name:		Address:	
How Long Employed?:		Occupation:	

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1. HOUSEHOLD INCOME: Please indicate the total GROSS INCOME (before taxes and other deductions) from all sources for all persons living in your household. We need documentation of all income sources. If you are unemployed and have no income from salary or wages, a Notarized Statement of Unemployment must be submitted. If you are living with and/or being supported by relatives or friends a Notarized Statement of Support must be submitted.

SOURCE:

Total Monthly Amount

Salary or wages from full or part-time employment: $_____
Required Documentation
Copies of check stubs for last 6 weeks OR
Statement from employer on company letterhead verifying gross income for last 6 weeks OR
If self-employed, complete copy of most recent for 1040.

Unemployment compensation: $_____
Required Documentation
Copies of last unemployment check OR
Copy of unemployment compensation worksheet

Workman's Compensation: $_____
Required Documentation
Copy of workman's compensation award letter

Social Security/SSI benefits: $_____
Required Documentation
Copy of last Social Security /SSI checks OR
Copy of Social Security /SSI award letter

Alimony or child support: $_____
Required Documentation
Copy of divorce decree or court order

Public assistance: $_____
Required Documentation
Copy of public assistance award letter

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SOURCE:

Total Monthly Amount

All Others:

Required Documentation

Copies of pay vouchers or statements

Veteran's Benefits $_____

Survivor Benefit: $_____

Pension or Retirement Payments: $_____

Interest, Dividends Payments: $_____

Income from estates and trusts: $_____

Rental Income: $_____

Educational assistance: $_____

Outside the house hold and other miscellaneous sources:

$_____

2. Proof of ineligibility for State/Federal/Local medical assistance programs unless applicant is known not to be eligible for such coverage. (If we are unable to determine your eligibility by your income, you must provide proof of a denial).
3. A valid current form of identification for the patient, parents, or guardian. This can include a passport, alien registration card, work authorization or any picture ID with the name and address printed on it.
4. Proof of address – This can include a copy of your lease, mortgage statement, rent receipt, or a notarized letter from your landlord.
5. If applicable, school verification or report card for the patient

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If you are applying because you are underinsured and need assistance with co-pays, deductible or co-insurance please include information on your medical expenses

Medical Expenses:

Children's Hospital: $_____

All Others: $_____

Required Documentation

1. Copies of medical bills paid or unpaid for all family members for the past 6 months

Certification and Authorization Statement:
I hereby certify that the information given on this application and any supporting documentation is accurate and complete to the best of my knowledge and ability. I authorize Children's National to verify this information as it may deem appropriate in reviewing my application for financial assistance and/or extended payment arrangements. I understand this review process may also include a check of my credit history through local credit reporting services. I also understand that submission of incomplete or inaccurate information may result in the reversal of any financial assistance (discount) awarded, and/or the withdrawal of approval for extended monthly payment arrangements.

Patient/Parent /Guardian Signature:	Relationship to Patient:	Date:
Parent/Guardian/ Spouse Signature:	Relationship to Patient:	Date: