The HSC Pediatric Center
Washington, DC
Financial Assistance Application

INSTRUCTIONS:

1. Please complete all areas on the attached application form. If any area does not apply to you, write N/A in the space provided.

2. Attach an additional page if you need more space to answer any question.

3. You must provide proof of income when you submit this application. The following documents are accepted as proof of income:
   If you filed a federal income tax return you must submit a copy:
   a. Federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service;
   b. Federal W-2 Form showing wages and earnings;

   If you did not file a federal income tax return, please provide the following:
   c. Two (2) most recent paycheck stubs;
   d. Two (2) most recent check stubs from any Social Security, child support, unemployment, disability, alimony or other payments;
   e. Two (2) consecutive bank statements;
   f. If you are paid only in cash, please provide a written statement explaining your income sources.

   If you have no income, please provide a letter explaining how you support yourself/family.

4. Your application cannot be processed until all required information is provided.

5. It is important that you complete, sign and submit the financial assistance application along with all required attachments within fourteen (14) days.

6. You must sign and date the application. If the patient/guarantor and spouse provide information, both must sign the application.

7. If you have questions, please call your account representative.

8. Please return the completed application to:
   The HSC Pediatric Center
   Attn: Business Office/Patient Accounting
   1731 Bunker Hill Road, NE
   Washington, DC 20017

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PATIENT/ GUARANTOR NAME		**SPOUSE NAME**	
ADDRESS		**PHONE**	
		Home	
		Work	
SOCIAL SECURITY NUMBER			
Patient/ Guarantor		**Spouse**	

FAMILY STATUS:
List all dependents that you support (additional space available on page 4)

Name	Age	Relationship

EMPLOYMENT STATUS	
Patient/Guarantor Employer	**Position**
Contact Person	**Telephone**
Spouse Employer	**Position**
Contact Person	**Telephone**

INCOME

	Patient/Guarantor	Spouse
1. Gross Wages & Salary (before deductions)		
2. Self-Employment Income		
3. Interest & Dividends		
4. Real Estate Rentals & Leases		
5. Social Security		

6. Alimony		
7. Child Support		
8. Unemployment/Disability		
9. Public Assistance		
10. All Other Sources (attach list)		
Total Income (add lines 1 - 10 above)		

UNUSUAL EXPENSES

Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (additional space available on page 4 - attach list as needed).

Description	Amount

ASSETS

Please provide an accurate estimate of value for each asset you own. Also, indicate how much you owe on any outstanding debt related to each asset listed.

Asset	Value	Amount Owed
1. Primary Residence		
2. Other Real Estate (attach list)		
3. Motor Vehicles (attach list)		
4. Other Personal Property		
5. Bank Accounts & Investments		
6. Retirement Plans		
7. Other Assets (attach list)		
Total Amounts (add lines 1 – 7 above)		

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize **The HSC Pediatric Center** to verify any information listed in this application. We expressly grant permission to contact my/our employer, banking and lending institutions, and to check my/our credit history.

_____ _____

Signature of Patient/Guarantor Signature of Spouse

_____ _____

Date Date