Shriners Hospitals for Children®

Charity Care & Transportation and Housing Assistance Application

Shriners Hospitals for Children is committed to providing care to children with neuromusculoskeletal conditions, burn injuries and certain other special healthcare needs without cost to the patients, their family members, or their guardians. We are asking that you help us fulfill our financial responsibilities so we can accurately document patients who qualify for charity care and transportation assistance.

Please Answer Each Question

The need for charity care & transportation and housing assistance may be reevaluated at each subsequent time of services if the last financial application relevant to the eligibility of the patient for charity care & transportation assistance is over 12 months old or the household's financial situation changes.

Child's Name_____ **Date of Birth**____/____/_____ **Gender** Male/Female (circle)

Child's Home Address_____ **City/State/Zip**_____

Social Security Number _____-_____-_____

Parent/Guardian Information

Name_____ **Relationship to child**_____

Home Address_____ **City/State/Zip**_____

Social Security Number _____-_____-_____ **Primary Phone Number** (____)_____

Total number of dependent family members living at home (include self)_____

Number of children (ages 0 – 21), included in the above number, living at home_____

Medicaid Application

Please check the appropriate statement boxes below: Attach copies of Medicaid notices including all attachments to the notices.

I/We ☐have / ☐have not applied for Medicaid to cover these services. Please explain reason_____

_____

I/We ☐have / ☐have not been rejected by Medicaid. Reason for reject (please include a copy)

_____

I/We ☐have / ☐have not been rejected by CHIP (Children's Health Insurance Program)

_____

I/We received an approval from Medicaid, but with a monthly spend down rate of $_____

FOR HOSPITAL USE ONLY:

MR # or FIN # _____

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Check the box and provide documentation, if any of the following circumstances apply:

- ☐ State-funded prescription programs;
- ☐ Homeless or received care from a homeless clinic;
- ☐ Participation in Women, Infants and Children programs (WIC);
- ☐ Food stamp eligibility;
- ☐ Free/reduced/discounted school lunch program eligibility;
- ☐ Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
- ☐ Low income/subsidized housing is provided as a valid address; and
- ☐ Parent is deceased with no known estate.

Household Income (Monthly)

Wages

a) **Total wages of Patient/Responsible Person**_____(attach a copy of paycheck stub)
b) **Employer Name**_____
c) **Employer Address**_____
d) **Spouse's Name**_____
e) **Total Wages of Spouse**_____(attach a copy of paycheck stub)
f) **Spouse's Employer Name**_____
g) **Employer Address**_____

Other Income

a) **Disability Payments**_____
b) **Alimony/Child Support**_____
c) **Retirement Benefits**_____
d) **Investment Income**_____
e) **Unemployment Compensation**_____
f) **Other**_____

I hereby affirm that the above statements are correct and complete, and I give my consent to further verification by Shriners Hospitals for Children or its agents.

_____
Printed Name

_____ Date_____
Signature

Please be sure to enclose all requested income information before submitting your application. Incomplete or fraudulent applications will be denied.

- ☐ Wage/Income statements for the past 90 days
- ☐ Complete prior year's tax return
- ☐ Copy of insurance/Medicaid denial notices
- ☐ Social Security determination notices

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