

Financial Assistance Application

If you have questions or need help completing this application, please call the Financial Counselors at (214) 456-8640.

Complete Name of Guarantor/Guardian ↓

Stepfather/Stepmother? Yes No

Last	First	M.I.	Social Security Number	
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Employer Name	Work Phone		Home Phone	Date of Birth
Home Address		City	State	Zip

Complete Name of other Guarantor/Guardian ↓

Stepfather/Stepmother? Yes No

Last	First	M.I.	Social Security Number	
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Employer Name	Work Phone		Home Phone	Date of Birth
Home Address		City	State	Zip

Please list all of your children (IN HOUSEHOLD) below:

Name Last, First	Social Security #	Date of Birth	Insurance/Medicaid Information	OFFICE USE MR#

Wages/Salary Guarantor #1 \$ _____	Vehicle(s)	Year/Model	Value
Wages/Salary Guarantor #2 \$ _____	#1	_____	\$ _____
Child Support Paid Received \$ _____	#2	_____	\$ _____
Other (specify) \$ _____	Home (Mo. Payment) \$ _____	Saving Accounts \$ _____	_____
TOTAL \$ _____	Checking Accounts \$ _____	Stocks/Bonds \$ _____	_____
GRAND TOTAL \$ _____	Other (specify) \$ _____	_____	_____
GRAND TOTAL \$ _____			

(Examples of proof of household income include recent Federal Tax Return Form 1040, Department of Human Services Form 1049, 4 paycheck stubs with year-to-date income, Social Security Letters or deposit slips, unemployment compensation letter or check stubs, letter of support) In order to be considered for assistance, please provide applicable documents. In certain situations, when documents are not available, verbal attestation may be taken from the legal guardian in lieu of documents.

- Patient's social security card (if applicable)
- Patient's Birth Certificate or Passport
- Proof of household income (see examples above)
- Proof of United States Residency (current utility, telephone, or cable bill)

Children's Health works with University of Texas Southwestern Medical Center ("UTSW") to provide financial assistance for our patients receiving professional services from UTSW to the same extent such assistance would be available under the Children's Health financial assistance policy.

Signature of Guarantor/Guardian

Date

FC Signature:

Application Valid Thru:

*By signing this application I certify the above information is true and accurate to the best of my knowledge and any attached documentation is accurate and complete to the best of my ability. I authorize Children's to investigate this information for this screening. If it is determined the applicant submitted false information, the application will be automatically denied.