Application and Eligibility Determination for Financial Assistance

Patient Name: _____ **Date:** _____

Parent or Guardian's Name(s): _____

Address: _____

_____

_____

Applicant's Family Income (previous 12 month's income) $ _____

Number of Family Members: _____

Dates of Service Requested: _____

Income includes: a) Net receipts from rentals and self-employment b) Gross wages, social security and railroad retirement, unemployment and workers' compensation, public assistance, child support and alimony, pensions, dividends, grants, interest, scholarships, military allotments, and net gambling winnings. A family is a group of people related by birth, marriage or adoption who reside together.

Please attach the following:

- **a copy of the previous year's filed 1040 tax return, including Schedule 1, if applicable**
- **a statement indicating any circumstances or subsequent adjustments to income level**

I certify that the above information is true and accurate to the best of my knowledge and I understand that the information provided is subjected to verification by Blythedale Children's Hospital. Further, I will make an application for any assistance that may be available for payment of any Hospital charges (Medicaid, Insurance, etc.) and I will assign or pay to the Hospital that amount recovered for Hospital charges. If any information I have given proves untrue, I understand that the Hospital may reevaluate my financial status and take whatever action is appropriate.

Date of Request: _____ **Applicant Signature:** _____

Eligibility Determination

(completed by Blythedale Children's Hospital)

Date Application Received: _____ *Income Verified? Yes:* _____ *No:* _____

Application Approved: 100% Free _____ *Pending* _____ *Final* _____

Application Denied: Income exceeds Federal Guideline _____ *Other (specify):* _____

Other uncompensated services: Approved _____ *Denied:* _____ *Payment %:* _____

Date of Decision: _____ *Preparer's Signature:* _____ *CFO Signature:* _____

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