

Children's Cardiology

Financial Assistance Application



Please return within thirty (30) days.

To apply for a discount on medical services your child received at Children's Healthcare of Atlanta Cardiology ("Children's Cardiology"), please supply all the information requested below. If we do not receive a completed Financial Assistance Application and all proofs of income for all members of the household, we will not be able to provide any type of Financial Assistance discount and the application will be closed. If you have any questions regarding Children's Cardiology financial assistance, call us at (770) 488-9204, extension 8008, Monday - Friday, 8:30am - 4:00pm.

Proof of Income Documentation

Documentation required for proof of wages or salary. Both are required:

- Two (2) most recent pay stubs for all employed members of the household. For example, four (4) pay stubs if two parents are working. If self-employed, a Profit and Loss Statement is required.
- AND
- Most recent 1040 Tax Form(s) for entire household.

If the person applying for Financial Assistance is not employed or can't provide pay stubs, there are alternative options.

Documentation required for proof of no employment

A signed letter of Financial Support from the person supporting your household. Example Financial Support letter from your household's supporter:

I, (Printed name of person supporting your family), am the (Relationship to household) of (names in household being supported). I attest that they have resided at the following address:

From (Date) to (Date)

During these dates, I provided food, shelter, and basic necessities. I understand that I am in no way responsible for their medical bills. Please contact me should you have any questions.

(Signature of person supporting your household)

(Date of signature)

(Phone Number of person supporting your household)

Documentation for proving employment with no pay stubs

An Employment verification letter from your employer if they don't provide pay stubs. Example Employment Verification Letter from employer not providing pay stubs:

Business Name, Address, and Phone Number

Household Name, Address, and Phone Number

To Whom it may concern:

This letter is to inform the working status of (Household Name). Their job is (description of job) and their average income is (pay amount) on a (frequency of pay) basis.

(Signature of business manager)

(Date of signature)

Children's Cardiology Financial Assistance Application

Please return within thirty (30) days.

Guarantor Account # _____

Patient Name: _____ Male____ Female____
Last First Middle

Patient Date of Birth _____ Date of Service (s): _____

Applicant Information

Name: Dr. Mr. Mrs. Ms. _____

Street Address: _____

City: _____ State: _____ Zip: _____

No. Years at This Address: _____

Marital Status: Married ____ Divorced ____ Single ____ Separated ____

Number of Children: _____

Email Address _____

Name of Employer: _____

No of Years with This Employer: _____

Position/Title: _____ Business Phone: _____

Spouse or Co-applicant Information

Name: Dr. Mr. Mrs. Ms. _____

Street Address: _____

City: _____ State: _____ Zip: _____

No. Years at This Address: _____

Marital Status: Married ____ Divorced ____ Single ____ Separated ____

Number of Children: _____

Name of Employer: _____

No of Years with This Employer: _____

Position/Title: _____ Business Phone: _____

Applicant		Spouse or Co-Applicant	
Wage per Hour	\$	Wage per Hour	\$
Hours per Week	\$	Hours per Week	\$
Social Security per month	\$	Social Security per month	\$
Disability per month	\$	Disability per month	\$
Net Rental Income	\$	Net Rental Income	\$
Unemployment per month	\$	Unemployment per month	\$
Child Support per month	\$	Child Support per month	\$
Alimony per month	\$	Alimony per month	\$
Public Assistance	\$	Public Assistance	\$
Other	\$	Other	\$
Monthly Total	\$	Monthly Total	\$

If married, spouse information must be included on application.

Monthly Living Expenses

Home Mortgage Pymt	\$	Unpaid Balance	\$
Rent Pymt	\$	Unpaid Balance	\$
Utilities	\$	Unpaid Balance	\$
Automobile	\$	Unpaid Balance	\$
Loans	\$	Unpaid Balance	\$
Credit Cards	\$	Unpaid Balance	\$
Insurance	\$	Unpaid Balance	\$
Doctor	\$	Unpaid Balance	\$
Hospital	\$	Unpaid Balance	\$
Other	\$	Unpaid Balance	\$
Total	\$	Total	\$

If you have not listed income, please explain how are you paying for food and housing:

Consent and Agreement

I confirm that the information in this application is correct and complete and that Children's Cardiology has my permission to double-check it for accuracy. I understand that if Children's Cardiology finds any of this information to be intentionally false, I will not be eligible for financial assistance and will be responsible for all charges.

Signature of Applicant: _____ Date: _____

Signature of Spouse or Co-Applicant: _____ Date: _____

FINANCIAL ASSISTANCE DISCOUNT RATES

Household Income as a Percentage of FPL	Financial Assistance Discount
0 to 400%	100%
401% to 500%	75%
501% to 600%	50%

Household Income as a percentage of current FPL, based on U.S. Census Bureau 2025 guidelines:

		Criteria		
		400% FPL	500% FPL	600% FPL
Family Size	100% 2026 FPL	100% Discount	75% Discount	50% Discount
1	\$ 15,960	\$ 63,840	\$ 79,800	\$ 95,760
2	\$ 21,640	\$ 86,560	\$ 108,200	\$ 129,840
3	\$ 27,320	\$ 109,280	\$ 136,600	\$ 163,920
4	\$ 33,000	\$ 132,000	\$ 165,000	\$ 198,000
5	\$ 38,680	\$ 154,720	\$ 193,400	\$ 232,080
6	\$ 44,360	\$ 177,440	\$ 221,800	\$ 266,160
7	\$ 50,040	\$ 200,160	\$ 250,200	\$ 300,240
8	\$ 55,720	\$ 222,880	\$ 278,600	\$ 334,320

Please submit application to Children's Cardiology via fax to 404-256-8927.
 If unable to fax the application, you may submit the form via mail or email.
 Children's Healthcare of Atlanta Cardiology, Attn: Financial Counseling
 2970 Brandywine Road, Suite 125, Atlanta, Georgia 30341
 Email: financialcounseling@kidsheart.com