

As described more fully in our Financial Assistance Policy,<sup>1</sup> Children's Healthcare of Atlanta provides financial assistance to help Guarantors pay for patients' medical bills. Services provided to the patient must be for Medically Necessary Care and the **Guarantor must have a balance of at least \$500** due after all third-party payments expected have been received to qualify for Children's Financial Assistance. To apply for a discount on medical services your child received at Children's, 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 financial assistance, call us at 404-785-5515, Monday to Thursday from 8:30 a.m. to 4 p.m. or Friday from 8:30 a.m. to noon.

## **Proof of Income Documentation**

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

- Two (2) most recent paystubs 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 and 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)

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<sup>1</sup> Please see our Financial Assistance Policy at <https://www.choa.org/-/media/Files/Childrens/patients/bills-and-insurance/2025/financial-assistance-policy-english.ashx>. Any capitalized term used in this Application and not otherwise defined here should be defined in the Policy.

## **Eligibility for Assistance**

Patients and Guarantors meeting screening criteria for any of the programs below are expected to complete the appropriate application process in order to be eligible for Financial Assistance.

These programs include:

- Medicaid (including Emergency Medicaid, Medically Needy and Katie Beckett programs);
- PeachCare for Kids;
- Medicare;
- Group Health Insurance Plans;
- Employer continuation of coverage (COBRA);
- Georgia Medicaid Health Insurance Premium Program (HIPP/CHIPRA); or
- Individual Health Insurance Plans, including those available on the HealthCare.gov Health Insurance Marketplace.

Residents of Georgia may qualify for funds provided by the Georgia Indigent Care Trust Fund (Trust Fund), as well as other funding sources. A person is a resident if he or she has entered the state with a job commitment or is actively seeking employment and not receiving assistance from another state.

Eligibility for Financial Assistance will be determined within ninety (90) days of when we receive a complete Financial Assistance Application and proof of income. A Guarantor's accounts will be put on hold pending the determination of eligibility for Financial Assistance. Completion of the application is not a guarantee of financial assistance from any source.

If additional medical services occur after your application is submitted, please notify us so we can determine if the services provided qualify for a Financial Assistance discount and whether the Guarantor will need to complete another application and provide any additional supporting documentation.

If you have any questions regarding Children's financial assistance, call us at 404-785-5515, Monday to Thursday from 8:30 a.m. to 4 p.m. or Friday from 8:30 a.m. to noon. Information is also available on-line at [choa.org](http://choa.org).

The completed application and supporting documentation can be e-mailed to:

[financialassistanceapplications@choa.org](mailto:financialassistanceapplications@choa.org)

Completed application may also be mailed to:

Financial Resource Coordinator  
Children's Healthcare of Atlanta  
1575 Northeast Expressway  
Atlanta, GA 30329

## Financial Assistance Application



Guarantor Number	
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Patient Name(s)	Date of Birth	Medical Record Number	Most Recent Date of Service

### Applicant

### Spouse or Co-Applicant

Title		
Name		
Street Address		
City, State ZIP		
Marital Status		
Home Phone		
Mobile Phone		
Number of Children		

### Employment

Employer		
Employer Street Address		
Employer City, State ZIP		
Position/Title		
Business Phone		
Years with Employer		

### Income

	Frequency	Frequency
Wages (including salary, bonuses, tips and self-employment income)		

Frequency can be Yearly, Monthly, Bi-weekly, Weekly, or Hourly

### Other Income per Month

Interest, dividends, royalty income		
Social Security, SSI		
Disability		
Rental Income		
Unemployment		
Child Support		
Alimony		
Public Assistance		
Retirement income, trusts, pension payments		
Other		

## Health Coverages Available for Payment



Please list all health insurance plans available for family members

Insurance Plan	Enrolled Member	Insurance ID	Group ID

Are any of the following a source of payment for Children's Healthcare of Atlanta services?

Plan Name

Do Not Have

Health share plans/ministries

\_\_\_\_\_

☐

Short-term health insurance

\_\_\_\_\_

☐

Limited-liability health insurance

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☐

In these instances, Children's does not file a claim for charges incurred and Guarantors may be eligible for Financial Assistance discounts on the balance outstanding.

If Children's provides a standard claim form or other documentation to support a potential claim on behalf of the patient, a Financial Assistance discount will not be granted until the Guarantor has provided Children's with documentation of payment amount or denial by the entity providing health coverage.

**Financial Assistance discounts will be applied to the balance outstanding following application of amounts paid by any out-of-network and non-standard health coverages.**

## Consent and Agreement

I confirm that the information in this application is correct and complete and give Children's Healthcare of Atlanta has my permission to verify. I understand that if Children's Healthcare of Atlanta finds any of this information to be intentionally false, I will not be eligible for financial assistance and will be responsible for all charges.

I understand that I must disclose any payments received for Children's Healthcare of Atlanta services from health insurance or other coverages to Children's Healthcare of Atlanta and those payments may reduce discounts for outstanding balances. Failure to provide this payment information may void eligibility for discounts for past and future services provided.

**Applicant**

**Spouse or Co-Applicant**

Signature		
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:

		2025 Children's Financial Assistance Criteria		
		400% FPL	500% FPL	600% FPL
Family Size	100% 2025 FPL	100% Discount	75% Discount	50% Discount
1	\$ 15,650	\$ 62,600	\$ 78,250	\$ 93,900
2	\$ 21,150	\$ 84,600	\$ 105,750	\$ 126,900
3	\$ 26,650	\$ 106,600	\$ 133,250	\$ 159,900
4	\$ 32,150	\$ 128,600	\$ 160,750	\$ 192,900
5	\$ 37,650	\$ 150,600	\$ 188,250	\$ 225,900
6	\$ 43,150	\$ 172,600	\$ 215,750	\$ 258,900
7	\$ 48,650	\$ 194,600	\$ 243,250	\$ 291,900
8	\$ 54,150	\$ 216,600	\$ 270,750	\$ 324,900