Children's Financial Application Form

Children's Healthcare of Atlanta at Egleston and Scottish Rite provide financial assistance for families to help pay children's medical bills. To apply for free or a reduced rate on medical services that have already been provided by Children's Healthcare of Atlanta, please supply all the information requested on the attached form: proof of income, including your most recently completed tax forms, W2's, as well as copies of your most recent paycheck stubs.

If we do not receive all information requested, as well as proof of income, we will not be able to process the application and the application will be closed, and the patient and/or guarantor will receive a bill for the outstanding balance.

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.

If you are not a resident of Georgia or there are any special considerations you would like us to consider, please use this same form to request consideration for financial assistance to the Trust Fund. Consideration of these requests will be determined by the availability of other funding sources for qualified applicants. Please note that completion of the application is not a guarantee of financial assistance from any source.

Within 60 days, you will be notified of the Committee's decision. While the decision is being made, your accounts will be put on hold.

Please remember that your application covers only medical services that have already taken place. If medical services occur after your application is submitted, please notify us so we can determine whether or not you need to complete another application.

If you have any questions regarding Children's financial assistance, please call us at (404) 785-5060, Monday through Friday, 8:30am - 4:00pm. Information is also available on-line at www.choa.org.

Please mail the completed application to:

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

As noted above, please attach the following as proof of income: most recent 1040 tax form with the accompanying W-2's as well as two most recent pay stubs. You may also fax the completed application and proof of income to (404) 785-9236. *Applications without proof of income will not be considered for financial assistance.*

Children's℠
Healthcare of Atlanta

Financial Statement

(Please Print)

Account #(s): _____ MR #: _____

Patient Name: _____ Male _____ Female _____
Last *First* *Middle*

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

Applicant Information

Name: Dr. Mr. Mrs. Ms. _____

Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

No. Years at This Address: _____

Marital Status: Married ____ Divorced ____ Single ____ Separated ____

Number of Children: _____

Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

No of Years with This Employer: _____

Position/Title: _____ Type of Business: _____

Home Phone: _____ Business Phone: _____

Spouse or Co-applicant Information

Name: Dr. Mr. Mrs. Ms. _____ _____

Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

No. Years at This Address: _____

Marital Status: Married ____ Divorced ____ Single ____ Separated ____

Number of Children: _____

Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

No of Years with This Employer: _____

Position/Title: _____ Type of Business: _____

Home Phone: _____ Business Phone: _____

For Office Use Only

_____

_____

_____

Advisory Board:

_____

Comments:

_____

Monthly Income before Taxes

Please attach the following as proof of income: Most recent 1040 tax form with accompanying W-2s as well as two most recent pay stubs. ***Applications without proof of income will not be considered for financial assistance*****.**

Applicant		Spouse or Co-Applicant*	
Wage per Hour	$	Wage per Hour	$
Hours work per week		Hours work 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	$
(list)		(reason)	
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 Healthcare of Atlanta has my permission to double-check it for accuracy. 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.

Signature of Applicant: _____ Date: _____

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