Children's Hospital Colorado

CHILDREN'S HOSPITAL COLORADO FINANCIAL ASSISTANCE PROGRAM

Attention: Financial Counseling
13123 E 16th Ave B-280
Aurora, CO 80045
Direct # 720-777-7001
Fax #: 720-777-7124

SECTION 1: APPLICANT

Last Name	First Name	M.I.	S.S.N.

Address	Home Phone

City	State	Zip	County	Work Phone

	List household members (First/Last)	Relationship	Date of Birth	S.S.N	Residency
1					
2					
3					
4					
5					
6					
7					

SECTION 2: UNDOCUMENTED EMERGENCY MEDICAID

Applied For:	_____ YES	_____ NO	DATE: _____	COUNTY: _____

SECTION 3: FUNDING SOURCE

Wyoming Fund _____	Mesa County Fund _____	Undocumented _____	400% _____	Out-of-State: _____ (indicate state)

SECTION 4: EMPLOYMENT

Name of Employer		Work Phone

Address	City	State	Zip

Name of Employer		Work Phone

Address	City	State	Zip

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SECTION 5: CALCULATING INCOME

	Income	Current Monthly Amount		Annual Total
1	Current employment gross income	$ _____	x12	$ _____
2	Self-Employment Income	$ _____	x12	$ _____
3	Unearned Income	$ _____	x12	$ _____
4	Monthly Income	$ _____	x12	$ _____
5	TOTAL INCOME	$ _____	x12	$ _____

Calculating Equity in Resources

6. Vehicle Equity (list) Vehicle 1 _____ Vehicle 2 _____ Vehicle 3 _____	Value $_____ $_____ $_____	Amount Owed $_____ $_____ $_____	Vehicle Equity $_____ $_____ $_____	Minus Protected Portion $ 7,500.00	Adjusted Equity $_____
7. Real Property (other property besides primary home)	Value $_____	Amount Owed $_____	Equity $_____	**********	Adjusted Equity $_____
8. Liquid Resources Checking $_____ Savings $_____ Bonds $_____ Mutual Funds $_____	Value $_____	Amount Owed $_____	Equity $_____	**********	Adjusted Equity $_____
9. Business Equity	Value $_____	Amount Owed $_____	Equity $_____	$ 50,000	Adjusted Equity $_____
10. Total Equity in Resources	Total Resources				Adjusted Equity $_____
11. Less Family Size Deduction	Family Size _____ X $2,500.00				Amount $_____
12. Equity in Resources (line 10 minus line 11)					Amount $_____
13. Total Family Fin Status (line 5 plus line10 minus line 11)	If line 11 is greater than 10 amount is $0				Amount $_____
14. Minus Allowable Deductions (daycare, child support paid, medical ins premium, etc.)	(See Attached Page)				Amount $_____
15. Net Income and Resource Equity (Line 13 minus Line 14)	Grand Total				Amount $_____

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FOR OFFICE USE ONLY:

Ability to Pay Rate: _____

CLIENT CO-PAY CAP (Line 15 X 0.10) $_____

Effective From: _____ To: _____

OUTSTANDING BALANCE(S) OWED: $_____

Payment Arrangements Established: Y / N

I CERTIFY THAT THE INFORMATION PROVIDED TO COMPLETE THIS APPLICATION IS TRUE. I UNDERSTAND THAT *CHILDREN'S HOSPITAL COLORADO* HAS A RIGHT OF RECOVER. THIS MEANS THAT IF I AM FOUND TO HAVE A CLAIM FOR ANY BENEFITS PAYABLE, FOR ANY TREATMENT WHICH IS GIVEN WHILE I AM ELIGIBILE FOR *CHILDREN'S HOSPITAL COLORADO CHARITY PROGRAM,* THAT THIS PROVIDER HAS THE RIGHT TO BE INCLUDED IN THE CLAIMS PROCESS.

Applicant Name	Signature	Date
Print Financial Counselor Name	Financial Counselor Signature	Date

CALCULATION TAPE

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WORKSHEET 1: EMPLOYMENT INCOME AND UNEARNED INCOME

Record all income and cash from other sources on this page and attach to the application.

PAYMENT SOURCE	MONTHLY AMOUNT
Employment Income	$
Old Age Pension Benefits (OAP)	$
SSI (Supplemental Security Income)	$
AND (Aid to the Needy Disabled)	$
Payment(s) and Pension Plans Source:_____ Source:_____	$
Commissions, Bonuses and Tips	$
Alimony Received	$
Rental Income	$
Monetary Gains	$
Trust Account Funds	$
Settlements	$
Other Source:_____ Source:_____	$
TOTAL	$
TOTAL (monthly amount) $_____ X12 $_____ = Annual Income	$_____

Applicant Name _____ Signature _____ Date _____

Print Financial Counselor Name _____ Financial Counselor Signature _____ Date _____

CHILDREN'S HOSPITAL COLORADO FINANCIAL ASSISTANCE PROGRAM

WORKSHEET 2: NET SELF-EMPLOYMENT INCOME

Record all monthly Business related expenses on this page and attach to the application.

EXPENSE	MONTHLYAMOUNT
Business Insurance	$
Labor/Payroll	$
Merchandise/wholesale cost of inventory	$
Rent for Business Space	$
Interest on Business Mortgage	$
Business and Income Taxes	$
Equipment Upkeep and Maintenance	$
Utilities (Electricity) $_____ (Phone) $_____ (Heat) $_____	$
Equipment	$
Supplies	$
Professional Services	$
Education, Licensing and Certification Fees	$
Business related travel	$
TOTAL (monthly amount) $_____ X12 $_____ = Annual Income	$_____

_____

Occupation Title

Applicant Name	Signature	Date
Print Financial Counselor Name	Financial Counselor Signature	Date

WORKSHEET 4: ALLOWABLE DEDUCTIONS

Record all allowable deductions this page and attach to the application

DEDUCTION	MONTHLYAMOUNT
Child Care/Day Care/Preschool	$
Court Ordered Alimony/Pension	$
Court Ordered Child Support	$
Health Insurance Premiums	$
Elder Care	$
<u>Paid Medical Expenses</u> Provider:_____ Date Paid_____ Amount $_____ Provider:_____ Date Paid _____ Amount $_____ Provider:_____ Date Paid _____ Amount $_____ Provider:_____ Date Paid _____ Amount $_____	$
Monthly Prescriptions	$
<u>Out Standing Medical Expenses</u> Provider:_____ Amount $_____ Provider:_____ Amount $_____ Provider:_____ Amount $_____ Provider:_____ Amount $_____	$
GRAND TOTAL	$

Applicant Name _____ Signature _____ Date _____

Print Financial Counselor Name _____ Financial Counselor Signature _____ Date _____

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PLEASE REFER ALL QUESTIONS TO THE FINANICAL COUNSELING DEPARTMENT, 720-777-7001
MONDAY THRU FRIDAY 8:00 AM TO 4:30 PM

Documentation Requirements

One of the following is required:

	ORIGINAL Birth Certificate (Copies/faxes are not acceptable)
	United State Passport and/or VISA
	Certificate of Naturalization (Form N-550/N-570)

	Certificate of Birth Abroad (Form FS-545/DS-1350
	Report of Birth Abroad of US Citizenship (Form FS-240)
	US Citizen Identification Card (Form I-97)

ALL documents pertaining to Income, Non-Work Income and if applicable Child Support Payments

Verification of Income (Any of the following items regarding income verification is required to determine eligibility	☐ One month of Pay Stubs showing GROSS Income ☐ Letter from Employer Stating Hourly Wage, Hours Worked, Pay Frequency, Gross Pay (before taxes and deductions) and TIPS if Applicable on Company ☐ If your employment has stopped, please bring a letter from your previous employer indicating your last day of employment
Self Employment (if applicable) **ALL** documents must be submitted.	☐ Three months of ledgers or Profit and Loss Statements indicating income and expenses paid. ☐ Three months of Bank Statements for the Business showing Deposits made and expenses being paid. (i.e. Jan 1- Mar. 31)
Non- Work Income (if applicable) Any of the following items related to non-work income require a check stub, court order document, legal document, etc..	☐ SSDI (Social Security Disability Income) ☐ SSI (Supplemental Security Income) ☐ SSA Survivorship Income ☐ Child Support Payments ☐ Unemployment Benefits (letter from state unemployment showing gross pay and frequency) ☐ Alimony ☐ Pensions ☐ Any other non-work income
Verification of Expenses Paid (if applicable) Need proof of payment(s)	☐ Child Support Payments Paid ☐ Health Insurance, Dental Insurance and Optical Insurance Premiums
If you do not work and are staying with Friends/Relatives etc., please have them write a letter of support that includes the following:	Name, address, contact phone number and the total number of people living in the household

In addition to US Citizenship/Identity and Income Documents you may be requested to provide original documents for the following items:

- ☐ State Issued Driver's License (or) State Issued Identification Card AND
- ☐ Social Security Card (s) for EACH applicant AND
- ☐ Proof of Colorado Residency (e.g., utility bill, mortgage statement, lease agreement, etc…) with applicants name and address

If applicable:

- ☐ Bank Statements for all bank accounts
- ☐ Primary Insurance card/Proof of insurance premiums
- ☐ Vehicle Registration(s) (provide value of your vehicle and if financed bring in proof of balance of auto loan)
- ☐ Separated or divorced: Court document(s) indicating separation or divorce