# CHC FINANCIAL'S ASSISTANCE PROGRAM
# WE WANT TO HELP.

At Children's Health Council, it is very important to us that your family receives needed services. We have financial assistance that may be available to you to help with the cost of services delivered by CHC. To determine eligibility, CHC takes several things into consideration including annual household income, number of individuals supported by your family's income, clinical needs, insurance coverage, and special situations facing your family.

| Client Name: | | | | Date of birth: | |
|---|---|---|---|---|---|
| **PARENT/GUARDIAN INFORMATION (if client is under 18 or over 18 and parents are paying for services.)** | | | | | |
| First Parent/Guardian name: | | | | | |
| Phone number: | | | | Email address: | |
| Second Parent/Guardian name: | | | | | |
| Phone number: | | | | Email address: | |
| **Please list Monthly Income** | | | | | |
| | Gross Income (Total Earned each month) | Deductions: Taxes | Deduction: Insurance | Deductions: 401k/Savings | Monthly Net Income |
| Client or if under 18 first Parent | | | | | |
| Second Parent | | | | | |
| Total (all sources) | | | | | |

| Please list Monthly Expenses (if in the same household, please combine expenses under Client or First Parent.) | | | | | | |
|---|---|---|---|---|---|---|
| | Mortgage /Rent | Utilities | Food | Car Payment/Gas | Educational Expenses | Other |
| Client or if under 18 First Parent | | | | | | |
| Second Parent | | | | | | |
| Total | | | | | | |

Please list all the people in your household (children, grandparents) or living elsewhere (college, elderly home) that are dependent on your income:

If Monthly Expenses are greater than Monthly Net Income, please explain how they are paid for (savings, family, friends, other work:

Will you be receiving reimbursement from your insurance company for some or all of the services? __ Yes __No
If yes, please summarize how much you will be reimbursed for.

Please indicate in detail any other reasons for your financial assistance request including but not limited to special circumstances, one-time medical expenses, extenuating circumstances, etc.

I, _____, certify that the above is accurate and true.

Signature:_____ Date:_____