111 Michigan Ave NW
Washington, DC 20010-2916
ChildrensNational.org

Children's National Hospital/Rehabilitation and Specialized Care
Financial Assistance Application

Children's National Hospital/Rehabilitation and Specialized Care (CNH/RSC) will offer financial assistance to patients who are unable to pay their hospital and/or clinic bills due to difficult financial situations regardless of age, gender, race, creed, disability, social or immigrant status, sexual orientation, or religious affiliation. A Children's National Hospital/Rehabilitation and Specialized Care Financial Counselor, designated business office representative, or committee with authority to offer financial assistance will review individual cases and make a determination of financial assistance that may be offered.

Medically necessary care is considered medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health-related illness, condition or disability including services necessary to prevent a detrimental change in medical, behavioral, mental, or dental health status.

Eligibility for financial assistance will be considered for individuals who are uninsured, underinsured, ineligible for any government health care benefit program, or unable to pay for their care. Patients whose family income is at or below 400% of the federal poverty level and who have resided in our service area for at least 6 months are eligible for full financial assistance. Patients who reside outside our service area may be eligible for services required to treat and stabilize an emergent medical condition.

Financial need will be determined in accordance with procedures that involve verifying income and residency in our service area. The patient or the patient's guarantor will be required to complete the FAP Application and, for full financial assistance, provide the following:

1. Documentation of gross monthly Family Income. These documents will include pay stubs for the last six (6) weeks worked, or award letters for unemployment, worker's compensation, or public assistance, alimony, retirement, and/or disability income. This can include notarized support and unemployment statements. If self- employed, provide an income tax return for the past 2 years.

2. A valid current form of identification for the patient, parents, or guardian. This can include a passport, alien registration card, work authorization, or any picture ID with the full name and complete address printed on it.

3. Proof of address – This can include a copy of your lease, mortgage statement or a notarized letter from your landlord.

4. If applicable, school verification or report card for patient(s).

5. Proof of ineligibility for State/Federal/Local medical assistance programs unless applicant is known not to be eligible for such coverage. (If we are unable to determine your eligibility by your income, you must provide proof of a denial).

   DC-www.healthlink.com, MD-www.mydhr.org, VA – 855.242.8282

6. Qualifying patient/parents must provide proof of submission for Department of Health programs in order to be considered for temporary Financial Assistance. These include but not limited to:
   - CHILDRENS MEDICAL SERVICES
   - CARE FOR KIDS
   - Commercial insurance paid through Department of Health programs
   - Public and private medical assistance programs

7. Other documents as needed to determine eligibility.

Children's National Hospital/ Rehabilitation and Specialized Care (CNH/RSC) shall determine whether or not patients are eligible to receive financial assistance for deductibles, co-insurance, or co-payment responsibilities. Children's National Hospital/ Rehabilitation and Specialized Care will make reasonable efforts to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs. Children's National Hospital/Hospital for may make inquiries to obtain reports from third parties to determine whether they may be presumptively eligible (presumptive eligibility) for financial assistance to relieve the financial burden.

Full financial assistance will be denied for patients that submit an incomplete application or submit documents that cannot be verified. Those found eligible for full financial assistance will be eligible for a period of one year from the approval date. At that time, patients will need to re-apply for continued financial assistance by contacting the Financial Information Center. Presumptive eligibility is granted for one visit only.

Call the Financial Information Center at 800-787-0021 option 6 if you need assistance in completing the application or have any questions about the review process. Mail your completed application along with all the required documents to Children's National 111 Michigan Avenue (FIC room 1820) Washington, DC 20010.

Children's National Hospital/Rehabilitation and Specialized Care
Financial Screening Application Form

In order that we can assist you in a timely and efficient manner, please follow these instructions for completion of the application form.

1. Please Print or Type all requested information.

2. Please Sign and Date the application when completed (both parents must sign if both are in the home).

Request for: Check One

	Presumptive Eligibility – Applicable to one visit or procedure
	Full Financial Assistance –one year eligibility period requires all supporting documentation

PATIENT INFORMATION: Please list below those children for whom you are requesting assistance.

Last Name	First Name	DOB	Male / Female

OTHER DEPENDANTS: Please list below any other dependents (other than the children listed above or the parents listed on the next page) residing in your household.

Last Name	First Name	DOB	Male / Female

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PARENT/GUARDIAN INFORMATION: Please complete for both parents/guardians:

Patient/Parent/ Guardian Last Name:		First Name:	
Age:	Social Security Number:	Relationship to Child(ren):	
Home Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:		
Employer Name:	Address:		
How Long Employed?:	Occupation:		
Second Parent/Guardian/Spouse Last Name:	First Name:		
Age:	Social Security Number:	Relationship to Child(ren):	
Home Address (if different from above):	City:	State:	Zip Code:
Home Phone:	Work Phone:		
Employer Name:	Address:		
How Long Employed?:	Occupation:		

1. HOUSEHOLD INCOME: (All Applicants) Please indicate the total GROSS INCOME (before taxes and other deductions) from all sources for all family members living in your household. For full financial assistance, we need documentation of all income sources. If you are unemployed and have no income from salary or wages, a Notarized Statement of unemployment must be submitted. If you are living with and/or being supported by relatives or friends a Notarized Statement of Support must be submitted.

SOURCE:

Total Monthly Amount

Salary or wages from full or part-time employment: $_____

Required Documentation for Full Financial Assistance

Copies of check stubs for last 6 weeks OR
Statement from employer on company letterhead verifying gross income for last 6 weeks OR
If self-employed, complete copy of most recent for 1040.

Unemployment compensation: $_____

Required Documentation for Full Financial Assistance
Copies of last unemployment check OR
Copy of unemployment compensation worksheet

Workman's Compensation: $_____
Required Documentation for Full Financial Assistance
Copy of workman's compensation award letter

Social Security/SSI benefits: $_____
Required Documentation for Full Financial Assistance
Copy of last Social Security /SSI checks OR
Copy of Social Security /SSI award letter

Alimony or child support: $_____
Required Documentation for Full Financial Assistance
Copy of divorce decree or court order

Public assistance: $_____
Required Documentation for Full Financial Assistance
Copy of public assistance award letter

SOURCE:

Total Monthly Amount

All Others:
Required Documentation for Full Financial Assistance
Copies of pay vouchers or statements

Veteran's Benefits $ _____

Survivor Benefit: $ _____

Pension or Retirement Payments: $ _____

Interest, Dividends Payments: $ _____

Income from estates and trusts: $ _____

Rental Income: $ _____

Educational assistance: $ _____

Outside the household and other miscellaneous sources:

$ _____

For Full Financial Assistance, please also submit:

1. Documentation of gross monthly Family Income. These documents will include pay stubs for the last six (6) weeks worked, or award letters for unemployment, worker's compensation, or public assistance, alimony, retirement, and/or disability income. This can include notarized support and unemployment statements. If self- employed, provide an income tax return for the past 2 years.
2. A valid current form of identification for the patient, parents, or guardian. This can include a passport, alien registration card, work authorization, or any picture ID with the full name and complete address printed on it.
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   - Public and private medical assistance programs
7. Other documents as needed to determine eligibility

If you are applying because you are underinsured and need assistance with co-pays, deductibles or co-insurance please include information on your medical expenses.

Medical Expenses:

CNH/RSC: $ _____

All Others: $ _____

Required Documentation for Full Financial Assistance

1. Copies of medical bills paid or unpaid for all family members for the past 6 months

Certification and Authorization Statement:
I hereby certify that the information given on this application and any supporting documentation is accurate and complete to the best of my knowledge and ability. I authorize Children's National Hospital/Rehabilitation and Specialized Care to verify this information as it may deem appropriate in reviewing my application for financial assistance and/or extended payment arrangements. I also understand that submission of incomplete or inaccurate information may result in the reversal of any financial assistance (discount) awarded, and/or the withdrawal of approval for extended monthly payment arrangements.

Patient/Parent /Guardian Signature:	Relationship to Patient:	Date:
Parent/Guardian/ Spouse Signature:	Relationship to Patient:	Date: