



FINANCIAL EVALUATION FORM

1. APPLICANT (GUARANTOR) INFORMATION:

Relationship to Patient				Marital Status			
<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Other:				<input type="checkbox"/> Single <input type="checkbox"/> Married/Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separate			
Last Name		First Name			Middle Initial		
Date of Birth		Home Phone			Cell Phone		
Street Address		City		State	County		Zip
Current Employer		Employer's Address (Street, City, State)			Work Phone		
*If you are not working, how long have you been unemployed?							

If you marked **YES** to **Married or Domestic Partner**, please complete Section 2.

2. CO-APPLICANT (GUARANTOR) INFORMATION:

Relationship to Patient							
<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Other:							
Last Name		First Name			Middle Initial		
Date of Birth		Home Phone			Cell Phone		
Street Address		City		State	County		Zip
Current Employer		Employer's Address (Street, City, State)			Work Phone		
*If you are not working, how long have you been unemployed?							

3. FAMILY INFORMATION: Please provide names of everyone in the household.

Patient: Yes or No	Last Name	First Name	Middle Initial	Date of Birth	Employed	Gross Income
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Total Number of Household Members:						



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OTHER COVERAGE QUESTIONS:

Check Appropriate Answer

A)	Is the patient applying for assistance with bills for: <ul style="list-style-type: none"> • Past Services (indicate dates): • Future Services (indicate dates): 	<input type="checkbox"/> Yes <input type="checkbox"/> No	
B)	Does the patient have health insurance? If yes , please provide the following information:		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Health Insurance Name:	Subscriber Name:	
	Member/Patient Identification Number:	Group Number:	
	Group/Employer Name:	Effective Date:	Health Insurance Phone:

You must provide a copy of one of the following as verifiable proof of income:

- | | |
|--|--|
| <ul style="list-style-type: none"> • W-2 • Prior Year's Tax Return • Three Most Recent Pay Check Stubs • Proof of Child Support Income • Retirement Check Stubs | <ul style="list-style-type: none"> • Social Security Letters or Deposit Slips (showing the amount of the Social Security deposit) • Unemployment Check Stubs • Other Governmental Program Check Stubs • Letter from Employer (on company letterhead) indicating the payment amount |
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4. INCOME INFORMATION:

Monthly Income Sources	Applicant	Co-Applicant	Combined Monthly Income
Wages	\$	\$	\$
Public Assistance	\$	\$	\$
Social Security	\$	\$	\$
Unemployment Compensation	\$	\$	\$
Alimony	\$	\$	\$
Child Support	\$	\$	\$
Pension	\$	\$	\$
Income from Rent or Real Estate	\$	\$	\$
Dividends, Interest	\$	\$	\$
Other Income (describe)	\$	\$	\$
TOTAL COMBINED MONTHLY INCOME:			\$

DISCLOSURE: BEFORE APPLYING FOR FINANCIAL ASSISTANCE WITH COOK CHILDREN'S HEALTH CARE SYSTEM YOU MUST SHOW PROOF OF APPLICATION AND/OR DENIAL FROM MEDICAID, CSHCN, CHIP OR ANY OTHER STATE PROGRAM FOR WHICH YOUR CHILD MIGHT BE ELIGIBLE OR PROVIDE INCOME DOCUMENTATION THAT INDICATES ELIGIBILITY IS NOT POSSIBLE. FAILURE TO DO SO MAY RESULT IN AUTOMATIC DISQUALIFICATION.

Cook Children's Health Care System may require an applicant for financial assistance to furnish any information that is reasonably necessary to substantiate the applicant's eligibility. Failure to do so within the time frame set forth in Cook Children's Financial Assistance Policy will result in denial of eligibility, and the entire bill will be due and payable immediately. I also understand that if the information I submit is false, the request will be denied and any prior determination of eligibility for uncompensated services will be retroactively revoked and I will be responsible for payment of all charges. I certify that the information contained in the application is true, correct and complete. I understand that, should this request for financial assistance be denied for any reason, I will be fully responsible for financial obligations arising from health care services rendered by Cook Children's. I further understand that should I receive partial assistance, I will be fully responsible for the remaining balance.

5. SIGNATURE

Applicant / Co-Applicant	Date

Return completed application to:
 801 Seventh Avenue
 Fort Worth, TX 76104-2796

Or email to:
 CBOfinancialcounselor@cookchildrens.org

Or fax to:
 682-885-1396