CookChildren's.

| Subject: | Section: Financial | Policy Number: FN 300 | Page: |
|---|---|---|---|
| **FINANCIAL ASSISTANCE** | Application: System Wide | | Date of Issue: February 2025 |
| | Contact Person: AVP, Revenue Cycle | | Supersedes: January 2024 |
| Recommended:<br><br>Stephen W. Kimmel<br>EVP, System Finance | Approved:<br><br>Rick W. Merrill<br>President and CEO | | |
| Source of Policy:<br>Internal Revenue Code § 501(r)<br>Texas Health & Safety Code §§ 311.043-.045 | Review: Initial/Date | | |

## I. POLICY

In connection with its exemption from certain federal and state taxes, and in support of its mission to serve the health care needs of the community, Cook Children's Health Care System will provide financial assistance to eligible patients in accordance with this financial assistance policy (FAP). This FAP is also intended to satisfy Cook Children's Medical Center's (CCMC) and Cook Children's Medical Center – Prosper's (CCMC-P) obligation to provide community benefits through financial assistance in accordance with the provisions of Texas Health & Safety Code Sections 311.043-.045, and Internal Revenue Code Section 501(r).

Financial assistance will be granted, if qualified, without regard to age, sex, gender identity or expression, sexual orientation, physical or mental disability, race, creed, ethnicity, religion, language, or national origin.

An individual who is eligible for financial assistance under this FAP will never be charged more for emergency or other medically necessary care than the amounts generally billed to individuals with insurance.

## II. PURPOSE

To establish the framework by which CCHCS identifies patients who may qualify for financial assistance and to describe how CCHCS will determine patients' eligibility to receive full or discounted emergency and other medically necessary care.

## III. SCOPE

Subject to the exclusions set forth in Section V below, this FAP applies to all emergency and other medically necessary services provided by CCMC, CCMC-P, Cook Children's Physician Network (CCPN), and Cook Children's Home Heath (CCHH).

## IV. DEFINITIONS

| | |
|---|---|
| Family | A group of two or more people related by birth, marriage, or adoption and residing together. |
| Family Income | The annual earnings and cash benefits from all Family sources. Proof of earnings may be determined by annualizing the Family's year-to-date income, taking into consideration the current earnings rate. |
| Federal Poverty Guidelines | An annual guideline established by the U.S. Department of Health and Human Services that uses Household size and income to define the federal poverty level. Refer to Attachment A for the current year's Federal Poverty Guidelines. |
| Financial Assistance Committee | A committee of CCHCS with responsibility for considering appeals of financial assistance eligibility determinations, and considering and granting exceptions to any requirements, exclusions, or eligibility criteria set forth in this FAP. |
| Financially Indigent | Individuals whose Family Income is less than or equal to 500% of the Federal Poverty Guidelines. |
| Gross Charges | The full established price for medical care that is consistently and uniformly charged to patients before applying any contractual allowances, discounts, or deductions. |
| Household | A household consists of all the persons who occupy a housing unit (house or apartment), whether they are related to each other or not. |

| | |
|---|---|
| Medically Necessary Care | Those health care services that are reasonable and necessary to diagnose, prevent or treat an illness, injury or disease in a manner that is in accordance with generally accepted standards of medical practice and clinically appropriate in terms of types, frequency, extent and duration. |
| Medically Indigent | A patient who has been determined to be unable to pay for some or all of the patient's bills related to medical services because such bills (after all third-party payments, contractual adjustments, AGB discounts, financial indigency discounts, and other available adjustments or discounts have been applied) exceed a certain percentage of Family Income. |
| Non-exempt assets | Assets that are not exempt from bankruptcy and can be sold by a bankruptcy trustee to pay debts. |
| Presumptive Eligibility | Those individuals who have not submitted a complete application for financial assistance, but whose eligibility can be determined from publicly available information, or third-party predictive modeling software. |
| Primary Service Area | The primary service area is comprised of Tarrant, Parker, Johnson, Denton, Hood, Wise and Collin Counties. |
| Resident | An individual who is either a U.S. citizen or a lawful permanent resident and lives in the CCHCS Primary Service Area. A lawful permanent resident holds an alien registration/ I-551 card, more commonly referred to as a "green card." An individual who is in the U.S. on any type of visa is not a resident for purposes of qualifying for financial assistance under this policy. |
| Uninsured | An individual who does not have any health care coverage. |

## V. NON-COVERED PROVIDERS/SERVICES:

### A. Non-Affiliated Hospital Providers and Hospital Contracted Services

While this FAP applies to all physicians and other health care providers employed by CCHCS, CCMC, CCMC-P, CCPN and CCHH, it does not apply to, and a patient may be billed separately for, services provided at CCMC and CCMC-P by providers and contractors who are not employed by or otherwise affiliated with CCHCS. Refer to Attachment B for a list of CCHCS affiliated hospital providers covered under this FAP, as well as a list of non-affiliated hospital providers not covered under this FAP. This list will be reviewed on a quarterly basis and updated as appropriate.

### B. Elective and Excluded Procedures and Services

This FAP does not apply to elective procedures, or to certain other excluded procedures and services as listed in Attachment C. This list will be reviewed on a regular basis and updated as appropriate. The Financial Assistance Committee may grant exceptions on a case-by-case basis taking into account the nature of the patient's illness, the availability of alternative treatments, the likelihood that treatment will lead to a successful outcome, the disposition of similar cases, and the budgetary constraints of CCHCS. No one factor is determinative.

### C. High Dollar Pharmaceuticals and Therapeutics

This FAP does not apply to certain high dollar pharmaceuticals and therapeutics as listed in Attachment D. This list will be reviewed on a regular basis and updated as appropriate. The Financial Assistance Committee may grant exceptions on a case-by-case basis taking into account the nature of the patient's illness, the availability of alternative treatments, the likelihood that treatment will lead to a successful outcome, the disposition of similar cases, and the budgetary constraints of CCHCS. No one factor is determinative.

### D. Child Study Center

This FAP does not apply to programs or services provided by the Child Study Center including, but not limited to, Autism Services, the Behavior Disorders Clinic, and the Jane Justin School.

## VI. ELIGIBILITY EXCLUSIONS

### A. International Program and Global Health Services

Patients originating from the International Program or Global Health Services do not qualify for financial assistance under this FAP, regardless of whether the patient otherwise meets the eligibility criteria set forth in this FAP.

### B. Third-Party Claims and Settlements

A patient is not eligible for financial assistance under this FAP if the patient receives or is expected to receive a third-party financial settlement that includes payment intended to compensate the patient for charges related to medical care rendered by CCHCS. The patient is expected to use the settlement amount to satisfy any patient account balances. Any discount or write-off of charges shall not be construed as a waiver by CCHCS of its ability to enforce a hospital lien or

otherwise seek reimbursement of any amount owed by a third-party on behalf of a patient, including a third-party liability insurer. Financial assistance may be completely or partially reversed in the event of a recovery from a third-party or other source.

### C. Out-of-Network Plans with No Out-of-Network Benefits

A patient is not eligible for financial assistance under this FAP if they have coverage through a commercial insurance company that does not have a contract with CCHCS and will not pay out-of-network benefits to CCHCS or does not authorize services to be rendered at CCHCS.

### D. Health Care Sharing Ministries/Non-Regulated Plans

A patient is not eligible for financial assistance under this FAP if the patient is covered under a Health Care Sharing Ministries plan or other non-regulated alternative health plan. The Financial Assistance Committee may grant exceptions on a case-by-case basis, but the availability of financial assistance under this policy is always secondary to other payment sources.

### E. Patients Eligible for Government-Sponsored Programs Who Refuse to Apply

If CCHCS determines that a patient may qualify for a government-sponsored program such as Medicaid, Children's Health Insurance Program (CHIP), Children with Special Health Care Needs (CSHCN), or Supplemental Security Income (SSI), but the patient refuses to apply for assistance, the bill will not be considered for financial assistance. The patient will be responsible for the entire balance and payment of the estimated amount due at the time of the services.

## VII. CALCULATION OF AMOUNTS GENERALLY BILLED

A FAP-eligible individual may not be charged more for emergency or other Medically Necessary Care than the amounts generally billed (AGB) to individuals with insurance. CCHCS uses the "Look-Back Method" to calculate AGB by dividing the sum of Medicare fee-for-service, Medicaid, and private health insurer allowed claims by the associated Gross Charges for those claims. Claims during the prior fiscal year (12 months) are included in the calculation, and the AGB is calculated annually and applied on a calendar year basis. CCHCS will separately calculate the AGBs for CCMC and CCMC-P, but will apply the lower AGB calculation as the system-wide rate for all CCHCS entities. Refer to Attachment E for the current calendar year AGB calculations and a description of how those amounts were calculated.

## VIII. ELIGIBILITY FOR FINANCIAL ASSISTANCE

Except for patients who are admitted to CCMC or CCMC-P on an emergency basis, to be eligible for financial assistance under this FAP, the patient must be a U.S. citizen or lawful permanent Resident of the U.S., and must reside in CCHCS's Primary Service Area, or, if the patient resides outside the Primary Service Area, he/she must have a pre-established relationship with a CCHCS physician or provider.

Financial assistance will also be available under this FAP to patients who receive services at CCMC or CCMC-P on an emergency basis and do not have the resources to pay for those services, regardless of residency or citizenship status.

CCHCS may adjust the eligibility criteria from time to time based on the financial resources of the organization and as necessary to meet the needs of the community.

### A. Financial Indigence

To be eligible for financial assistance based on financial indigence criteria, a patient's Family Income must be at or below 500% of the Federal Poverty Guidelines, and there must be no other non-exempt assets available to pay the amounts due. Patients who are determined to be Financially Indigent and who otherwise meet the eligibility criteria set forth in this policy will receive a discount for eligible, Medically Necessary Care as follows:

| **Family Income as a % of Federal Poverty Guidelines** | **Discount** |
|---|---|
| Less than or equal to 400% | 100% |
| Greater than 400%, but no greater than 500% | 75% |
| Greater than 500% | 0% |

### B. Medical Indigence

To be eligible for financial assistance based on medical indigence criteria, a patient must meet ALL of the following conditions:

1. Medical bills after any third-party payment, contractual adjustment, self-pay discount, or financial indigence discount exceed the specified percentages of Family Income as indicated in the table below; and
2. No other non-exempt assets are available to pay the amounts due.

Patients who are determined to be Medically Indigent will be eligible for a discount that results in a maximum outstanding balance that does not exceed the percentages specified in the table below:

| **Family Income as a % of Federal Poverty Guidelines** | **Maximum obligation as a % of Family Income** |
|---|---|
| Greater than 400%, but no more than 500% | 5% |
| Greater than 500%, but no more than 600% | 10% |
| Greater than 600%, but no more than 700% | 15% |
| Greater than 700% | 20% |

If a patient is determined to be Medically Indigent, any previously applied uninsured/self-pay discount will be reversed out and will instead be applied as financial assistance. If the outstanding balance after application of medical indigence criteria exceeds the AGB, the outstanding balance will be further reduced to reflect AGB. Likewise, if the outstanding balance after application of medical indigence criteria exceeds the AGB, the outstanding balance will be further reduced to reflect the AGB.

### C. Automatic Eligibility

The following individuals are automatically eligible for 100% financial assistance related to their patient responsibility, with no application required. If any items listed below are used as a basis for determining the financial assistance discount, documentation should be retained on file for audit purposes.

1. Patient death – Following a patient's death, any amounts remaining due on the patient's account after payment by third-party payors will be automatically written off to financial assistance, to the extent permitted by applicable state and federal law, including payment rules and regulations promulgated by the Centers for Medicare & Medicaid Services and the Texas Health & Human Services Commission.

2. Medicaid eligible patients who have exhausted benefits.

3. Patients with Medicaid in the immediately prior or subsequent six months to the date of service under review.

4. Charges not covered under Medicaid as part of the Medicaid patient's spenddown.

### D. Presumptive Eligibility

An internal assessment of financial eligibility may be conducted in lieu of requiring the patient to complete the application process set forth in Section IX(D) of this FAP. This internal assessment process utilizes third-party software to conduct an electronic review of public record databases to estimate and take into account a patient's Family Income, Household size and employment status, and otherwise assess financial need and ability to pay.

Those individuals who otherwise meet the non-income-based eligibility criteria may qualify for financial assistance under this FAP based on the results of the internal assessment process. Those individuals who qualify for financial assistance using the internal assessment process, or who qualify for some but less than a 100% discount, will be notified of the basis for that decision and informed that they may nonetheless apply for financial assistance pursuant to Section IX(D) within 30 days of the date of the notice.

Services provided in a primary care office are not eligible for financial assistance based on the internal assessment process, but can be applied for using the application process set forth in Section IX(D) of this FAP.

### E. Uninsured/Self-Pay Discount

Uninsured patients who do not qualify for financial assistance may still be eligible for an uninsured/self-pay discount as set forth in CCHCS policy FN 670 Uninsured/Self-Pay Patient Discount.

## IX. PROCEDURE FOR IDENTIFYING ELIGIBILITY FOR FINANCIAL ASSISTANCE

To be considered for financial assistance, a Financial Evaluation Form must be on file with the Central Business Office, except that patients who are determined to be automatically or Presumptively Eligible for financial assistance may not require a Financial Evaluation Form.

**A. Application Period** – An application for financial assistance must be submitted no later than the 240th day after the date of the first post-discharge billing statement.

**B. Eligibility Determination Period** – Eligibility will be determined by reviewing Family Income for a period of up to three months prior to the applicable date of service or the prior tax year, if available. It is the goal of CCHCS to make a determination concerning the guarantor's eligibility for financial assistance as soon as sufficient information is available concerning the guarantor's financial resources and eligibility for governmental assistance. A determination of eligibility will be made within 30 days from the time all information necessary to make a determination is received.

**C. Qualification Period** – For patients whose eligibility is determined based on Presumptive Eligibility criteria, financial assistance will apply only to the date(s) of service for which the Presumptive Eligibility assessment was performed. For patients who complete the application process set forth in Subsection (D) below, financial assistance eligibility will extend to any eligible services provided up to six months prior to the applicable date of service and up to one year after the applicable date of service.

### D. Applying for Financial Assistance

1. Individuals may apply for financial assistance by completing the Financial Evaluation Form (see Attachment F) and submitting supporting documentation.

2. The following documentation of Family Income may be utilized to make an eligibility determination:

    i. W-2;
    ii. Prior year's tax return;
    iii. Pay check stubs;
    iv. Retirement check stubs;
    v. Social Security letters or deposit slips showing the amount of the Social Security deposits;
    vi. U.S. unemployment check stubs;
    vii. Other governmental program check stubs;
    viii. Letter from employer, on employer letterhead, indicating the payment amount;
    ix. Alimony or child support;
    x. Income from estates and trusts;
    xi. Income from dividends, rents, royalties, and interest income;

xii. Regular insurance or annuity payments;
xiii. In exceptional cases, verbal or written attestation may be used as proof of income.

**E. Incomplete Applications** – If all required documentation is not received (i.e., the application is incomplete), the applicant will be provided with a written notice that describes the additional information and/or documentation required to complete the application and will be given a reasonable opportunity to do so. The notice shall include the contact information, including the telephone number and physical location, of the department that can provide information about the FAP and assistance with the FAP application process. IRS regulations preclude any extraordinary collection activities during the 240 day application period.

**F. Disqualification** – An applicant who supplies false information as part of the application process will not qualify for financial assistance under this policy. Any financial assistance previously awarded based on such false information may be completely or partially reversed, and the patient will remain responsible for all outstanding balances.

## X. BILLING AND COLLECTION EFFORTS

**A. Billing Statements** - Following a determination of financial assistance eligibility, a billing statement will be provided to the individual that indicates the amount the individual owes as a result of being eligible for financial assistance.

1. The billing statement will indicate the amount the individual owes and how that amount was calculated. The billing statement may reflect gross charges that were used as the starting point before allowances, discounts or deductions were applied, provided that the amount that the individual is personally responsible for paying is less than the gross charges for such care.

2. The billing statement will provide a QR code as well as the website address (www.cookchildrens.org/financial-assistance) where the individual can go for information about the FAP, including the amounts generally billed (AGB) for the care provided, and how the AGB is calculated.

**B. Notifying Patients of the FAP Before Initiating Extraordinary Collection Activities (ECAs) –** At least 30 days before initiating one or more ECAs to obtain payment for care, CCHCS will notify patients about its FAP by:

1. Including a plain language summary of the FAP along with a notice of the ECA(s) that the hospital intends to initiate to obtain payment for the care, and a deadline after which such ECA(s) may be initiated (the deadline may be no earlier than 30 days after the date that the written notice is provided).

2. Making a reasonable effort to orally notify the individual about the FAP and how the individual may obtain assistance with the FAP application process.

**C. Safe-Harbor for Certain Charges in Excess of AGB –** If CCHCS does not know whether an individual is eligible for financial assistance and the individual has not submitted a complete application for financial assistance to CCHCS, it can bill the person its usual charges, provided that it subsequently makes timely attempts to determine the individual's

eligibility. Charges in excess of AGB shall not be made or requested as a pre-condition of providing medically necessary care to the individual. In addition, if any excess payments were made by the individual prior to being determined eligible for financial assistance, those payments, if over $5.00, must be refunded.

**D. Collection Efforts** – No collection efforts will be pursued until reasonable efforts have been made to determine financial assistance eligibility based on a complete FAP application, or in the case of an incomplete FAP application, the individual has failed to respond to the request for additional information and/or documentation within a reasonable period of time.

1. Agreements with collection agencies must state that they will not begin collection efforts until CCHCS has made reasonable efforts as indicated in this policy to determine whether the individual is eligible for financial assistance. If the individual is determined to be eligible, the collection agency must take all reasonably available measures to reverse any collection efforts (with the exception of the sale of debt) taken against the individual to collect the debt at issue.

2. Accounts worked by contracted collection agencies that have been screened for financial ability to pay, and are determined not to be able to pay account balances, will automatically be deemed eligible for financial assistance. Collection agencies will provide separate reports for accounts returned to CCHCS indicating the accounts where the guarantor does not have the ability to pay and those where the guarantor has been determined to have the ability to pay but refuses.

## XI. PUBLICIZING THE FINANCIAL ASSISTANCE POLICY:

CCHCS will widely publicize information in this FAP by:

1. Making paper copies of the policy, a plain language summary of the policy, and the Financial Evaluation Form available, in English and Spanish, upon request and free of charge, both by mail and in the ED and admission areas;

2. Conspicuously displaying signs and flyers with general information about the availability of financial assistance in public areas of CCMC and CCMC-P, including the ED and admission areas;

3. Notifying members of the community likely to need financial assistance of its availability by providing flyers for distribution at local agencies and nonprofit organizations that address the health needs of the community's low-income populations, along with instructions on how they may obtain more information;

4. Posting this FAP, a plain language summary of the policy, and the Financial Evaluation Form in an easily accessible location on the Cook Children's website;

5. Including a conspicuous written notice on all billing statements that notifies and informs recipients about the availability of financial assistance under the FAP and includes a telephone number of the department that can provide information about the FAP and the application process, as well as the website address where copies of the FAP, Financial Evaluation Form, and plain language summary of the FAP may be obtained; and

6. Offering a paper copy of the plain language summary of this FAP as part of the intake or discharge process.

## ATTACHMENTS

Attachment A: Federal Poverty Guidelines
Attachment B: Covered and Non-Covered Providers and Contracted Services
Attachment C: Excluded Procedures/Services
Attachment D: Excluded High Dollar Pharmaceuticals and Therapeutics
Attachment E: Calculation of Amounts Generally Billed
Attachment F: Financial Evaluation Form

## REFERENCES

Internal Revenue Code § 501(r)
Texas Health & Safety Code §§ 311.043-.045

## RELATED POLICIES

MC 011 Emergency Medical Screening and Transfer of Patients
FN 100 Billing Requirements
FN 175 Collection Requirement at Time of Service
AD 550 Undocumented Immigrants
FN 670 Uninsured/Self-Pay Patient Discount

*End of Policy*

## ATTACHMENT A

## 2025 FEDERAL POVERTY GUIDELINES

| Persons in Household | Federal Poverty Guidelines |
|---|---|
| | |
| 1 | $15,650 |
| 2 | $21,150 |
| 3 | $26,650 |
| 4 | $32,150 |
| 5 | $37,650 |
| 6 | $43,150 |
| 7 | $48,650 |
| 8 | $54,150 |

For Households with more than 8 persons, add $5,500 for each additional person.

## ATTACHMENT B

## COVERED AND NON-COVERED HOSPITAL PROVIDERS

### Cook Children's Medical Center

Providers Covered by this Financial Assistance Policy:

A list of physicians and other health care providers providing services at Cook Children's Medical Center and covered under this FAP is available here. You may request a paper copy of this list by calling 682.885.1860.

Providers Not Covered by this Financial Assistance Policy:

A list of physicians and other health care providers providing services at Cook Children's Medical Center who ***are not*** covered under this FAP is available here. You may request a paper copy of this list by calling 682.885.1860.

### Cook Children's Medical Center - Prosper

Providers Covered by this Financial Assistance Policy:

A list of physicians and other health care providers providing services at Cook Children's Medical Center – Prosper and covered under this FAP is available here. You may request a paper copy of this list by calling 682.885.1860.

Providers Not Covered by this Financial Assistance Policy:

A list of physicians and other health care providers providing services at Cook Children's Medical Center – Prosper who ***are not*** covered under this FAP is available here. You may request a paper copy of this list by calling 682.885.1860.

## ATTACHMENT C

## EXCLUDED PROCEDURES/SERVICES

- Transport services provided by any entity other than Cook Children's Teddy Bear Transport
- Outside laboratory services
- Durable medical equipment
- Solid organ transplants
- Bone marrow transplants

## ATTACHMENT D

## EXCLUDED HIGH DOLLAR PHARMACEUTICALS AND THERAPEUTICS

alglucosidase
amphotericin b liposome
basilimab
blinatimomab
clofarabine
dinutuximab
eculizumab
Elevidys
factors
infliximab
Kymriah
leuprolide
melphalan
mepolizumab
omalizumab
pegasparagase
pegfilgrastim
rasburicase
spinraza
supplrelin
Synagis
thrombin
Vedolizumab
Zolgensma

## ATTACHMENT E

## CALCULATION OF AMOUNTS GENERALLY BILLED

Following a determination of financial-assistance eligibility, an individual will not be charged more than the amounts generally billed (AGB) to individuals with insurance. CCHCS uses the "Look-Back-Method" to calculate AGB by dividing the sum of Medicare fee-for-service, Medicaid, and private health insurer claims allowed by the associated Gross Charges for those claims. Claims during the prior fiscal year (12 months) are included in the calculation. The AGB is calculated annually and applied on a calendar year basis. CCHCS will separately calculate the AGBs for Cook Children's Medical Center and Cook Children's Medical Center – Prosper, but will apply the lower AGB calculation as the system-wide rate for all CCHCS entities. See below for the most recent calculation of AGB.

Cook Children's Medical Center Fiscal Year 2024:

| | |
|---|---|
| Gross Charges: | $3,653,730,229 |
| Discounts/Contractual Adjustments: | $1,637,016,607 |
| Discount Rate: | 45% |
| AGB for Calendar Year 2025: | 55% |

Cook Children's Medical Center – Prosper Fiscal Year 2024:

| | |
|---|---|
| Gross Charges: | $172,474,013 |
| Discounts/Contractual Adjustments: | $57,746,025 |
| Discount Rate: | 33% |
| AGB for Calendar Year 2025: | 67% |

**CCHCS System-Wide AGB for Fiscal Year 2024: 55%**

# Attachment E
## FINANCIAL EVALUATION FORM

**1. APPLICANT (GUARANTOR) INFORMATION:**

| Relationship to Patient | Marital Status |
|---|---|
| ☐Self ☐Parent ☐Spouse/Domestic Partner ☐Other: | ☐Single ☐Married/Domestic Partner ☐Divorced ☐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 |
|---|
| ☐Self ☐Parent ☐Spouse/Domestic Partner ☐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 |
|---|---|---|---|---|---|---|
| | | | | | ☐Yes ☐No | |
| | | | | | ☐Yes ☐No | |
| | | | | | ☐Yes ☐No | |
| | | | | | ☐Yes ☐No | |
| | | | | | ☐Yes ☐No | |
| | | | | | ☐Yes ☐No | |
| | | | | | ☐Yes ☐No | |
| | | | | | ☐Yes ☐No | |
| | | | | | ☐Yes ☐No | |
| | | | | | ☐Yes ☐No | |
| **Total Number of Household Members:** | | | | | | |

CookChildren's

# FINANCIAL EVALUATION FORM

**OTHER COVERAGE QUESTIONS:** Check Appropriate Answer

| | | | |
|---|---|---|---|
| A) | Is the patient applying for assistance with bills for:<br>• Past Services (indicate dates):<br>• Future Services (indicate dates): | | ☐Yes ☐No |
| B) | Does the patient have health insurance? If **yes**, please provide the following information: | | ☐Yes ☐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**:

- W-2
- Prior Year's Tax Return
- Three Most Recent Pay Check Stubs
- Proof of Child Support Income
- Retirement Check Stubs
- 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

**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