

# Application for CSHN Financial Assistance

Patient ID#:
Household ID#:
Clinic Type:

Please provide Patient and Parent Information requested below.

Child/Patient's Name					
	Last Name	First Name	Middle Initial	Date of Birth	Social Security Number <b>Required for all new applications.</b>

Parent's Name(s): \_\_\_\_\_ Telephone: \_\_\_\_\_

Mailing Address				
	Street or Box Number	City/Town	State	ZIP

## Instructions for remainder of the application:

- All families are asked to complete item 1.
- If the CSHN patient has Medicaid/Dr. Dynasaur coverage, only items 1 and 5 need to be completed.
- Families without Medicaid/Dr. Dynasaur coverage who wish to apply for CSHN Financial Assistance should complete the entire application. (Items 1-5).
- Families who **DO NOT WISH TO APPLY FOR CSHN FINANCIAL ASSISTANCE AT THIS TIME** are requested to complete items 1, 2 and 5.
- The application is continued on the back of this sheet.

### 1. Does the patient have Medicaid or Dr. Dynasaur coverage at this time? (Please check YES or NO.)

	<b>YES</b>	<p>We have Medicaid/Dr. Dynasaur coverage. We understand that we should notify CSHN at once if coverage changes.</p> <p>CSHN will cover after-insurance balances for services authorized by CSHN but not covered by Medicaid/Dr. Dynasaur.</p> <p><b>If you answered YES to this question, you may simply sign the back of the application and return it to CSHN.</b></p>
	<b>NO</b>	<p>We do not have Medicaid or Dr. Dynasaur coverage.</p> <p><b>Please go on to Item 2.</b></p>

### 2. Do you wish to apply for CSHN Financial Assistance? (Please check YES or NO.)

	<b>YES</b>	Yes, we wish to apply for CSHN Financial Assistance. (Please go on to Item 3.)
	<b>NO</b>	No, we do not wish to apply for CSHN Financial Assistance at this time. We understand that we may attend CSHN clinics but that we (and our medical insurance) will be responsible for the cost of tests, treatment, supplies, medications, equipment and other services that may be authorized at clinic. We also understand that we may change our mind and apply for assistance at any time in the future. In the event that we apply later on, we understand that coverage is NOT retroactive.

**3. Household Income. (This item is required for families who are applying for Financial Assistance.)**

Annual Income:	Please report <i>Adjusted Gross Income</i> from your most recent federal Income Tax form.	\$
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OR...	You may calculate your family income by using the worksheet, below. Please check the box at the right if you use the worksheet.	
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**Family Income Worksheet**

Type of Income	Who received Income?	Gross Amount	Payment Period (weekly, monthly, annually, etc.)	This space for CSHN use only.
Wages				
Unemployment Insurance				
Other Income that you report to the IRS (specify):				

**4. Family Size: (Please complete the Family Size worksheet, below. All families applying for CSHN Financial Assistance are requested to complete this item.)**

Family Member			Number
Yourself		Enter 1 ⇒	
Spouse	Enter "1" if married or if you are counting an unmarried partner whose income you reported in item 3.	⇒	
Child(ren) under age 21	Enter number of children at home or, if living away from home, those whom you still claim as dependents.	⇒	
Others	Enter number of other people for whom you are financially responsible AND whom you claim as a dependent for tax purposes.	⇒	

**Note: If your family size and income fall within Vermont Medicaid eligibility guidelines, CSHN may request that you apply for Medicaid before we provide CSHN Financial Assistance.**

**5. Certification: The information I have provided is accurate to the best of my knowledge. I will provide verification if requested by CSHN.**

<b>Signature</b>	<b>Date</b>