

Financial Assistance Application



The Seattle Children's Financial Assistance Program may be able to help you with your Children's bills — even if you have insurance.

Our financial assistance is for medically necessary services. It is based on family income and hospital resources and is provided to children under age 21 whose primary residence is in Washington, Alaska, Montana or Idaho. Patients who do not meet these criteria may be eligible for financial assistance for emergency services only. Adults in our region who are 21 years old and older may be eligible for financial assistance to treat specific conditions which are best managed by Seattle Children's specialists and programs.

The Children's Financial Assistance Program is not a form of insurance. It only helps with healthcare bills from Seattle Children's Hospital, Children's Home Care Services, Children's University Medical Group and Odessa Brown Children's Clinic.

If you qualify for the program, we help pay for:

- Healthcare bills from Children's that insurance does not cover
- Very large hospital bills at Children's
- Your full bill at Children's

To apply for Children's financial assistance before, during or after your child's care at Children's, fill out the form on page 4.

We also offer these options:

- **Interest-free Payment Plan** – We can help you work out a monthly payment plan. You do not need to fill out the application form.
- **Self-pay Discount** – We offer a 25% discount on our healthcare services if you:
 - Are a U.S. resident.
 - Do not have an insurance company that will be paying or reducing any part of the bill.

Call 866-987-5770 (toll-free) to find out more or sign up for Children's financial assistance (also known as charity care).

Our financial counselors can also help you with these possible sources of financial assistance:

- **Medicaid** – Medicaid or state medical assistance can often pay for part or all of your child’s healthcare expenses, even if you are not eligible for other forms of aid from the state. Medicaid can also help pay for healthcare bills from other providers besides Children’s.
- **Community Health Access Program (CHAP)** – If you live in Washington, a staff person from CHAP may contact you about state programs.

For more information or for help filling out this form, please call the Children’s Business Office and ask to speak to a financial counselor:

206-987-5770

206-987-5786 (Spanish line)

866-987-5770 (Toll-free)

Free Interpreter Services

- In the hospital, ask your child’s nurse.
- From outside the hospital, call the toll-free Family Interpreting Line 1-866-583-1527.
Tell the interpreter the name or extension you need.
- For Deaf and hard of hearing callers 206-987-2280 (TTY)



4800 Sand Point Way NE
PO Box 5371
Seattle, WA 98105

206-987-2000
866-987-2000
(Toll-free for business use only)

www.seattlechildrens.org

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Seattle Children’s provides healthcare for the special needs of children regardless of race, sex, creed, ethnicity or disability. Financial assistance for medically necessary services is based on family income and hospital resources and is provided to children under age 21 whose primary residence is in Washington, Alaska, Montana or Idaho.

Children’s offers interpreter services for Deaf, hard of hearing or non-English speaking patients, family members and legal representatives free of charge. Children’s will make this information available in alternate formats upon request. Call the Family Resource Center at 206-987-2201.

To begin the financial aid process, complete this form and mail it in the envelope provided or bring it to a Children's registration desk.

If your child is already enrolled in Medicaid, Basic Health, Healthy Options or Basic Health Plus, you do not need to fill out this application form.

Your name as responsible party:

Birth date (month, day, year) _____ / _____ / _____

Mailing address

City _____ State _____ ZIP _____

Home phone number () _____

Please list all children or teens in your home receiving care at Children's:

Patient name _____

Birth date _____ / _____ / _____

Medical record # (if known) _____

Patient name _____

Birth date _____ / _____ / _____

Medical record # (if known) _____

Are there any other children or teens living in your home for whom you are responsible?

Yes No

Names and birth dates of other children under age 21 living in your home. If you are pregnant, please count the unborn child.

Name _____ Birth date ____ / ____ / ____

Name _____ Birth date ____ / ____ / ____

Name _____ Birth date ____ / ____ / ____

Name _____ Birth date ____ / ____ / ____

Do you have a spouse or is the child's other parent living with you?

Yes No

Name of spouse or child's other parent living at home

Birth date (month, day, year) _____ / _____ / _____

Do you work for someone else? Yes No

If yes, Monthly Gross Income

(This is your monthly family income before taxes are removed. It is not your take-home pay.)

Other Income (Do not include child support or public assistance.)

Do you work for yourself? Yes No

If yes, what is the amount your family takes home each month after business expenses? _____

Other income (Do not include child support or public assistance.) _____

If you have no listed income, please explain how you are paying for food and housing: _____

If you have health insurance, what is the name of the insurance?

Do you personally pay for some or all of your child(ren)'s monthly premium? Yes No

If yes, what amount do you pay? _____

Please note:

- We do not guarantee that you will qualify for Children's financial assistance even if you send in this application or get help from a Children's financial counselor.
- Once you send in your application, Children's may check all information in it. We may ask for proof of income (for example, pay stubs or a tax return).
- Fourteen days after we receive your application, we will send you a letter to let you know if you qualify for Children's financial assistance.

Consent and agreement

I confirm that the information in this application is correct and complete and that Children's has my permission to check it for accuracy. I understand that if Children's finds any of this information to be intentionally false, I will lose any Children's financial assistance, and I will be responsible for all hospital, clinic and doctor charges.

I also give Children's permission to release information on this application to the Community Health Access Program (CHAP), which might be used to search for other financial assistance sources.

_____ Date ____ / ____ / ____

Responsible party's signature

I would like a financial counselor to call me to discuss my other possible options for funding besides Children's financial assistance.