Seattle Children's®
HOSPITAL • RESEARCH • FOUNDATION

Application for Seattle Children's Financial Assistance (Charity Care)

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

If we need to contact you for additional information, do you need an interpreter?
☐ **Yes** ☐ **No** *If Yes, list preferred language:*

Have you applied for Medicaid for the patient? ☐ **Yes** ☐ **No**
(You may be required to apply before being considered for financial assistance. We will contact you if needed.)

Does the patient receive state public services such as TANF, Basic Food or WIC? ☐ **Yes** ☐ **No** ☐ **Not Sure**

Is the patient currently homeless? ☐ **Yes** ☐ **No**

Is the patient's medical care need related to a car accident or work injury? ☐ **Yes** ☐ **No**

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name or initial	Patient last name
Birth date		
Person responsible for paying bill	Relationship to patient	Birth date
Mailing address _____ _____ City State Zip code		Main contact number(s) ( ) _____ ( ) _____ Email address:

FAMILY INFORMATION

List all family members in your household, including you.
"Family" includes people related by birth, marriage or adoption who live together. **FAMILY SIZE** _____
Attach additional page if needed.

Name	Date of birth	Relationship to patient	Seattle Children's Medical Record Number (if known)	If 18 years old or older: total gross monthly income (income before taxes and deductions):

All adult family members' income must be disclosed. Sources of income include, for example:
Wages • Unemployment • Self-employment • Worker's compensation • Disability • SSI • Child/spousal support • Work study programs (students) • Pension • Retirement account distributions
We may ask you to provide proof of income such as pay stubs or last year's income tax return. We will contact you if we need those items.

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

MEDICAL INSURANCE AND EXPENSE INFORMATION

If your child has health insurance, what is the name of the medical 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? $_____/month

ADDITIONAL INFORMATION – ATTACH PAGE

Please attach an additional page if there is other information about your current financial situation you would like us to know (e.g., financial hardship, seasonal or temporary income, personal loss).

AGREEMENT

I understand Seattle Children's Hospital may verify the information on this form and may use other sources to help determine if I am eligible for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is false, I will be denied financial assistance, and I will be responsible for and expected to pay for services Seattle Children's provides.

_____ _____
Signature of person applying Date