Dear Parents,

We would like to thank you for your recent visit to Children's Hospital of Orange County Primary Care Clinics. It is our wish to provide superior care to your child, and serve as your health care partner.

We have noted that at the time of your visit you did not have health care insurance. If you do not have current insurance coverage, you may qualify for a government sponsored health plan such as Medi-Cal or Healthy Families. You might also qualify for financial assistance through our CHOC Financial Assistance Program. If you wish to apply, please complete the attached application and return it to the clinic where your child is seen along with the requested documentation within 15 days. You may also return your completed application and copies of income verification to:

CHOC Primary Care Business Services
455 South Main St.
Orange, CA 92868-3874

The following information and supporting documents must be provided to evaluate this application for possible reduction of clinic expenses provided by CHOC. Please complete all sections of the application and attach a copy of your proof of income in the form of one of the following:

- Check stubs for one month of income
- Employers statement of earnings
- Previous year income tax returns
- Letter of Unemployment/check stub

When proof of income is verified, your eligibility for financial assistance will be based upon Federal Poverty level guidelines. You will be mailed a copy of your application approval within one week of submission. Approval for financial assistance for your child's clinic visits will be valid for six months from date of approval.

If you have questions in reference to our Financial Assistance Application please contact the CHOC Business Office at 714-289-4825.

Thank you,

Carol Schoger, RN, BC
Manager CHOC Primary Care Business Services

CHOC Children's Clinic

Primary Care
Application for Financial Assistance

Todays Date:

Patient Name:		
Sex: ☐ Male ☐ Female		
Patients date of birth:	**Medical Record Number:**	
Guarantor Name:		
Address:		
City:	**County:**	
Telephone Number:	**Home** ☐ **Work** ☐ **Cell** ☐	
Does the patient have medical insurance?	**Yes**	**No**
Has patient applied for Medi-Cal or Healthy Families or other health plan?	**Yes**	**No**
Total Number of Family Members: (Include the parents and all children 21 and under)	**Family Children Ages:**	

Copies of <u>one</u> of the following documents must be attached as proof of income to evaluate this application for possible reduction of clinic expenses provided by CHOC.

- Check stubs for one month of income
- Employers statement of earnings
- Previous year income tax returns
- Statement of Unemployment

I certify that the information provided is true and accurate to the best of my knowledge. Further, I have or will apply for any assistance (Medi-Cal, Healthy Families, insurance, etc.) which may be available for payment of medical services. I will take any action reasonably necessary to obtain such assistance.

I understand that this application is a tool for the hospital to evaluate eligibility for charity services and is valid for six months from this date. I also understand that the hospital will verify the information which may include obtaining a credit report. If the information I have given proves to be untrue, or if I fail to comply with the referral process for MediCal, Healthy Families or other identified programs this may result in not being considered for the Financial Assistance Program.

Signature: _____ Relationship to Patient:_____

Printed Name: _____