FINANCIAL EVALUATION FORM

GUARANTOR NAME: _____ HOME PHONE: _____ CELL PHONE:_____

EMPLOYER: _____ WORK PHONE: _____

SPOUSE'S NAME: _____

EMPLOYER: _____ WORK PHONE: _____

GUARANTOR ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

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.

_____ _____

Signature Date

Mailing address:

801 Seventh Ave.
Fort Worth, TX 76104-2796
Email: hospitalbills@cookchildrens.org

Phone: 682.885.1860
Toll Free: 888.852.6635
Fax: 682-885-1396

INDIVIDUALS LIVING IN HOUSEHOLD:

	LAST	FIRST	RELATIONSHIP	AGE	GROSS INCOME
1.					
2.					
3.					
4.					
5.					

TOTAL NUMBER OF HOUSEHOLD MEMBERS: _____

ATTACH A COPY OF ONE OF THE FOLLOWING AS VERIFIABLE PROOF OF INCOME:

- **W-2**
- **PRIOR YEAR'S TAX RETURN**
- **PAY CHECK STUBS**
- **RETIREMENT CHECK STUBS**
- **SOCIAL SECURITY LETTERS OR DEPOSIT SLIPS SHOWING THE AMOUNT OF THE SOCIAL SECURITY DEPOSITS**
- **UNEMPLOYMENT CHECK STUBS**
- **OTHER GOVERNMENTAL PROGRAM CHECK STUBS**
- **LETTER FROM EMPLOYER, ON EMPLOYER LETTERHEAD, INDICATING THE PAYMENT AMOUNT**

INCOME INFORMATION:

Monthly Income:

Wages	$ _____
Public Assistance	$ _____
Social Security	$ _____
Unemployment compensation	$ _____
Alimony	$ _____
Child Support	$ _____
Pension	$ _____
Income from rent, real estate	$ _____
Dividends, interest	$ _____
Other income (describe) _____	$ _____
TOTAL INCOME:	**$ _____**