

APPLICATION and FINANCIAL DISCLOSURE
Children's HealthCare Fund

Name of Patient _____ Age _____ Birthdate _____
 Parent's / Guardian's Name(s) _____
 Mailing Address _____ Home Phone _____
 City/State/ZIP _____ Work Phone _____
 Number in Household _____ Number of Children _____ Ages _____
 Diagnosis _____

Amount Requested \$ _____ **Purpose / How will this impact the health of child / children (attach any supporting information):**

Other Sources Contacted for Assistance: _____ Outcome \$ _____
 _____ Outcome \$ _____

Is the Patient on WIC? YES NO Is the Patient on State Financial Aid YES NO
 Is the Patient on the Oregon Health Plan Plus YES NO Does the Family Receive Food Stamps? \$ _____
 Is the Patient Eligible for Disability Services YES NO Caseworker's Name _____
 Does the Patient go to Shriners Hospital or Clinics YES NO Phone Number _____

EMPLOYMENT AND FINANCIAL DATA

| Name of Person Employed | Name of Employer | Length of Employment | Mo. Take-Home |
|-------------------------|------------------|----------------------|---------------|
| _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | \$ _____ |

If Unemployed, Previous Employer _____ Unemployment Amount \$ _____
 How Long Employed? _____ How Long Unemployed? _____

Other Income (include SSI, TANF, Name _____ Source _____) \$ _____
 Self-Sufficiency Grant, child support, etc.) Name _____ Source _____ \$ _____

TOTAL MONTHLY INCOME \$ _____

(application will not be processed without a copy of prior year's tax return attached)

ASSETS

Checking Account - Bank Name Amount Savings Account - Bank Name Amount
 _____ \$ _____

Other Assets (list type of stocks, bonds, second home, recreational vehicles, etc.) : Value
 _____ \$ _____
 _____ \$ _____
 _____ \$ _____

TOTAL ASSETS \$ _____

MONTHLY EXPENSES

Mo. Payment

Home: Own - Mortgage Payment \$ _____ Property Taxes / month \$ _____ (if not included in mortgage payment) \$ _____
 Rent - Paid To: _____ \$ _____

(application will not be processed without a copy of mortgage payment coupon, copy of rent receipt, or copy of cancelled check attached)

Utilities: Gas \$ _____ Electricity \$ _____ Water \$ _____ Phone \$ _____ \$ _____

Food & Household Items: Groceries \$ _____ Household \$ _____ Repairs \$ _____ \$ _____

AutoExpenses: Payment \$ _____ Gas & Oil \$ _____ Repairs \$ _____ \$ _____

Clothing \$ _____ Miscellaneous (child care, etc.) _____ \$ _____ \$ _____

Insurance (out-of-pocket expenses) : Life \$ _____ Health \$ _____ Auto \$ _____ \$ _____

Drugs & Medical Supplies (out-of-pocket expenses) : Patient \$ _____ Family \$ _____ \$ _____

| <u>Creditors Name & Address</u> (do not include mortgage payment or auto payment) | Balance Owing | Mo. Payment |
|---|---------------|--------------------|
| _____ | \$ _____ | \$ _____ |
| _____ | \$ _____ | \$ _____ |
| _____ | \$ _____ | \$ _____ |

| <u>Medical Creditors Name & Address</u> | Balance Owing | Mo. Payment |
|---|---------------|--------------------|
| _____ | \$ _____ | \$ _____ |
| _____ | \$ _____ | \$ _____ |
| _____ | \$ _____ | \$ _____ |
| _____ | \$ _____ | \$ _____ |

TOTAL MONTHLY EXPENSES \$ _____

MEDICAL / INSURANCE INFORMATION

Name of Doctor _____ Phone _____
Insurance Name _____ Group Number _____
Address _____ ID Number _____
Phone _____ Insured's Name _____
Yearly Deductible \$ _____ MET NOT MET Office Visit Co-Pay \$ _____
How Much Do You Pay Per Year in Co-Pays for Patient? \$ _____ Medication Co-Pay \$ _____

THE ABOVE INFORMATION IS WARRANTED TO BE TRUE TO THE BEST OF MY KNOWLEDGE. I hereby authorize Mercy Foundation to investigate the references herein listed or statements of other data obtained from me or from any other person pertaining to my credit and financial responsibility, and/or any medical/psychosocial conditions or needs disclosed. I hereby authorize Mercy Foundation to use the name of the patient and/or parent/guardian listed above, and/or pictures of the those same persons for the benefit of Mercy Foundation. I understand I may revoke the authorization for the use of the name(s) and/or pictures at any time by notifying Mercy Foundation in writing. **IF YOU DO NOT UNDERSTAND ANY OF THE ABOVE PLEASE CALL 677-4818 FOR FURTHER EXPLANATION.**

_____ Yes, names and/or pictures may be used for the benefit of Mercy Foundation (read the authorization above before checking)
_____ No, names and/or pictures may not be used for the benefit of Mercy Foundation

Signature of Applicant: _____ Date: _____