CHC FINANCIAL'S ASSISTANCE PROGRAM:
WE WANT TO HELP.

At the Children's Health Council, it is very important to us that your family receives needed services. We have financial assistance that may be available to you to help with the cost of services delivered by CHC and we encourage you to apply. To determine eligibility, CHC takes several things into consideration including annual household income, number of individuals supported by your family's income, clinical needs, insurance coverage, and special situations facing your family.

FINANCIAL ASSISTANCE APPLICATION					
Client Name:			Date of birth:		
PARENT/GUARDIAN INFORMATION					
Adult Client or Parent/Guardian A name:					
Phone number:			Email address:		
Parent/Guardian B name:					
Phone number:			Email address:		
HOUSEHOLD INFORMATION					
Adult Client or Parent/Guardian A	Number of individuals in household:	Number of dependent children:	Number of dependent adults:	Gross Monthly Income:	Monthly Expenses:
Parent/Guardian B	Number of individuals in household:	Number of dependent children:	Number of dependent adults:	Gross Monthly Income:	Monthly Expenses:

Please indicate in detail any reasons for your financial assistance request, including but not limited to, monthly expenses and special circumstance (i.e. loss of employment, childcare, medical expenses, etc.).

I, _____, certify that the above is accurate and true.

Signature:_____ Date:_____