



To: Prospective Clients  
Subject: Financial Aid Application Process

It is the policy of Children's Health Council to provide services regardless of ability to pay for those services when at all possible.

Financial aid may be available to you to defray the cost of recommended services delivered by Children's Health Council. To determine eligibility, we take into consideration annual household income, number of individuals supported by your family's income, clinical needs, insurance coverage and special financial situations facing the family. All families are asked to contribute some amount toward the cost of services.

You will be contacted regarding eligibility within three business days. Notice of approval will include the financial aid amount awarded. We will work with you to establish a reasonable payment plan for your portion of payment for services.

If you wish to apply for financial aid, please provide the following:

- ( 1 ) Completed financial aid application
- ( 2 ) A copy of your most recent federal tax return, including schedules. All tax returns will be shredded after review.
- ( 3 ) A cover letter explaining any financial circumstances that may not be reflected in the application, e.g., unemployment, medical expenses, etc.

Please mail, fax, email or hand deliver the completed application with the requested supporting documentation. If you have any questions please contact Andres Sierra at (650) 688-3685.

**Patient's Name:** \_\_\_\_\_

Parent (A) Name: \_\_\_\_\_ Parent (B) Name: \_\_\_\_\_

Number in Household: Adults: \_\_\_\_\_ Children: \_\_\_\_\_

Parent (A) Occupation: \_\_\_\_\_ Parent (B) Occupation: \_\_\_\_\_

Parent (A) Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent (A) Email: \_\_\_\_\_ Phone: \_\_\_\_\_

## GROSS MONTHLY INCOME

Father: \$ \_\_\_\_\_

Mother: \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_

**TOTAL INCOME:** \$  Number of Persons Dependent on Income: \_\_\_\_\_

## LIQUID ASSETS

Home (current market value): \$ \_\_\_\_\_

Other Property (current market value): \$ \_\_\_\_\_

Checking Account: \$ \_\_\_\_\_

Savings Account: \$ \_\_\_\_\_

Retirement Account: \$ \_\_\_\_\_

Stocks: \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_

**TOTAL ASSETS:** \$

## MONTHLY EXPENSES

Housing (mortgage/rent): \$ \_\_\_\_\_

Court Ordered Obligation: \$ \_\_\_\_\_

Child Care: \$ \_\_\_\_\_

Dependent Support: \$ \_\_\_\_\_

Medical Expenses: \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_

**TOTAL EXPENSES:** \$

## ADDITIONAL INSTRUCTIONS

- (1) Attach a copy of your latest federal tax return with all schedules. If no tax return was filed, please provide something to verify income.  
All tax returns will be shredded after review.
- (2) Attach a cover letter explaining any additional factors that should be considered.

**PLEASE MAIL, FAX, EMAIL OR HAND DELIVER ALL DOCUMENTS TO CHILDREN'S HEALTH COUNCIL, ATTENTION: ANDRES SIERRA.** I affirm that the above information is true and correct to the best of my knowledge. I understand that the information listed above is used to evaluate my eligibility for scholarship funding and will be held in strict confidentiality by Children's Health Council. In order to protect your personal information, all tax returns will be shredded after review.

Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_