



Lucile Packard Children's Hospital
Stanford University Medical Center

FAX COVER SHEET for
Packard Pediatric Weight Control Program
Financial Assistance Application

Please use this cover sheet when faxing your application to the financial assistance department to ensure prompt processing of your application.

DATE: _____ **TOTAL PAGES:** (Including this page) _____

TO: Patient Financial Advocacy Department
FAX #: (650) 493-8623 **Phone #: (650) 498-7421**

FROM: _____

FAX #: _____ **Phone#:** _____

RE: Financial Assistance Application for **Packard Pediatric Weight Control Program at Stanford**

MESSAGE: _____

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Patient Financial Advocacy Department
2690 Hanover Street
Palo Alto, Ca. 94304
Telephone: (650) 498-7421



Packard Pediatric Weight Control Program at Stanford Financial Assistance

Families requesting financial assistance are required to complete a financial assistance application and submit it with proof of their income to The Patient Financial Advocacy Department. Proof of income can be sent in the form of two recent pay stubs from each parent or legal guardian or the families' last filed tax return.

The Packard Pediatric Weight Control Program has a limited amount of partial and full financial assistance available.

- Partial Financial Assistance: Families who qualify are required to pay their reduced amount in full prior to the start of program.
- Full Financial assistance: Families, who qualify are required to make a deposit prior to their first session. A refund of this deposit will be paid after demonstrating regular attendance and completing the full series of counseling sessions.

When completing the financial assistance application remember to fill in all requested information to the best of your ability. If you are unable to provide any information, please use the comments space provided on the application to explain.

The information below *must* be included with your application. Failure to provide this information, or an explanation as to why this information is not available, may delay the processing of your application and could result in a denial for assistance:

- Provide copies of two most recent pay stubs OR last year's tax return for both applicant and co-applicant.

Every reasonable effort will be made to process your application as soon as possible. Completed applications may be faxed or mailed with the supporting documentation to the address listed below:

Patient Financial Advocacy
2690 Hanover Street Palo Alto, Ca. 94304
Phone: (650) 498-7421 Fax: (650) 493-8623



Lucile Packard Children's Hospital AT STANFORD



PEDIATRIC WEIGHT CONTROL FINANCIAL ASSISTANCE APPLICATION

DATE OF APPLICATION: ____/____/____

1. CHILD'S INFORMATION* - PLEASE PRINT ALL INFORMATION-					
Last Name		First Name		Middle Initial	Date of birth
2. APPLICANT (PARENT OR LEGAL GUARDIAN) INFORMATION					
RELATIONSHIP TO CHILD: <input type="checkbox"/> Parent <input type="checkbox"/> Other					
MARITAL STATUS: <input type="checkbox"/> Married/Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single					
Last Name		First Name	Middle Name	Social Security Number	
Date of Birth	No. of Dependents	Ages of Dependents			Home Phone
Street Address (Do Not List PO Box)		City		State	County Zip
Current Employer		Street Address, City, State			Position
* If you are not working, how long have you been unemployed?					
3. CO-APPLICANT (OTHER PARENT OR LEGAL GUARDIAN, IF LIVING IN HOUSEHOLD) INFORMATION					
RELATIONSHIP TO CHILD <input type="checkbox"/> Parent <input type="checkbox"/> Other					
Last Name		First Name	Middle Name	Social Security Number	
Date of Birth	No. of Dependents	Ages of Dependents			Home Phone
Street Address (Do Not List PO Box)		City		State	County Zip
Current Employer		Street Address, City, State			Position
* If you are not working, how long have you been unemployed?					

4. INCOME INFORMATION			
PROOF OF INCOME IS REQUIRED			
<u>Monthly Income Sources</u>	<u>Applicant (Parent or Legal Guardian)</u>	<u>Co-Applicant (Other Parent or Legal Guardian)</u>	<u>Combined Monthly Income</u>
Employment Income	\$	\$	\$
Social Security	\$	\$	\$
Disability	\$	\$	\$
Unemployment	\$	\$	\$
Spousal/Child Support	\$	\$	\$
Rental Property	\$	\$	\$
Investment Income	\$	\$	\$
Other[s] use these spaces	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
Total Combined Monthly Income			\$
UNEMPLOYMENT: If you do not have monthly income, please explain how you take care of your monthly expenses:			

5. ASSETS			
<u>Checking/Money Market/Savings Accounts:</u>		****List all available funds	
<u>Bank Name:</u>	<u>Branch/Address</u>	<u>Account Number</u>	<u>Current Balance</u>
1.			\$
2.			\$
3.			\$

6. ESTIMATED MONTHLY LIVING EXPENSES			
<u>Monthly Expenses</u>	<u>Monthly Payment</u>	<u>Monthly Expenses</u>	<u>Monthly Payment</u>
House/Mortgage Payment	\$	Current Outstanding Bills for Medical, Dental, or Prescriptions	\$
Property Taxes (if not included in mortgage payment)	\$	Total Monthly Automobile Payment(s)	\$
Home Owner's Insurance (if not included in mortgage payment)	\$	Automobile Insurance	\$
Utilities (Electricity, Gas, Water, Garbage, Recycling, etc.)	\$	Automobile Gasoline	\$
Food	\$	Liens/ Wage Garnishments	\$
Telephone (home line and/or cell)	\$	<u>List Other Monthly Payments</u>	\$
Child Support	\$		\$
Spousal Support/Alimony	\$		\$
Child Care	\$		\$
Credit Cards	\$		\$
Health Insurance Premiums	\$	Total Monthly Payments	\$

7. ADDITIONAL COMMENTS – IF YOU NEED MORE SPACE, PLEASE USE THE BACK OF THIS PAGE

8. SIGNATURE

I certify that all information is valid and complete and hereby authorize Lucile Packard Children’s Hospital to request a credit check report and/or verify any of the above information as deemed necessary.

**Applicant (Parent or Legal
Guardian) Signature**

Date

**Co-applicant (Other Parent
or Legal Guardian)
Signature**

Date

9. IMPORTANT REMINDER::

**Please include your Proof of
Income in the form of 2 recent
Pay-stubs for each applicant or
your last filed tax return.**

**If you are unable to provide
proof of income, please explain
why in the comment box above.**

Return your completed application to:

**SHC/LPCH Patient Financial Advocates
Patient Financial Services
2690 Hanover Street
Palo Alto, CA 94304
Or Fax to: **(650) 493-8623****