PLAYit FWD>> 4 KIDS

Charity Care Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help the board members of Play It Forward for Kids determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to sholmstrom@sportstherapylv.com with the following items.

1. a copy of the most recent tax return
2. a copy of the most recent 4 paystubs for all working family members
3. a copy of insurance cards or letter of medicaid eligibility (if applicable)

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

INSTRUCTIONS: COMPLETE THE APPLICATION IN FULL AND SIGN THE AUTHORIZATION TO VERIFY INFORMATION.						
PATIENT INFORMATION Email Address						
Last Name						FAMILY SIZE
Street	First	M.I.	Date of Birth	Social Security Number - -		
Employer	Apt. #	City	State	Zip Code		Home Phone
City		Address				Cell Phone
	State	Zip Code		Monthly Income		Work Phone
GUARANTOR / (SPOUSE IF RESPONSIBLE PARTY, PARENT IF MINOR)				Relationship to Patient		Date of Birth
Email Address						
Last Name	First	M.I.				Home Phone
Employer		Address				Cell Phone
City	State	Zip Code		Monthly Income		Work Phone

What organization does the athlete participate with: _____

Check as many that apply:

- ☐ WIC
- ☐ SNAP
- ☐ HOMELESSNESS
- ☐ MEDICAID ELIGIBLE
- ☐ TANF

Dependent Household members

Name	Age	Relationship

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Income Information

Please provide one or more of the following for each employed family member and sign the statement below.

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1. a copy of the most recent tax return
2. a copy of the most recent 4 pay stubs
3. copy of insurance cards / proof of medicaid eligibility

You may receive income or support from another source for example SSA, disability, child support, alimony, unemployment or workers' compensation, veteran's pension or disability, TANF, retirement income, or other income). Please indicate the source and amount of income

Income Source	Amount

If you cannot provide any documentation relating to your income, fill out the statement below:

I, _____(name), certify that I have no documents that prove my family's monthly income

Of $_____.

Other information

If you have additional documents that may help Advocate make a determination regarding your application, such as large outstanding bills which would show financial hardship, please provide those documents (example: phone bills, electricity bills, medical bills, bank or checking statements, etc....)

APPLICANT CERTIFICATION: I understand that the information provided may be verified by the charity, and I authorize the charity to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of services received.

Applicant Signature: _____ Date: _____

Please submit application and required documents to sholmstrom@sportstherapylv.com. If the application is **NOT** complete and the required documents are missing, the Application will not be approved. The board members meet on Mondays to review applications. Once the board reaches a final decision you will receive a response via email to the email address you provided.