Utah Department of Health & Human Services
Family Health

Personal Financial Form (PFR)

A

Patient Name:	DOB:

Primary Insurance Name:	Primary Insurance ID #:
Primary Policy Holder's Name:	Primary Insurance Group #:

Secondary Insurance Name:	Secondary Insurance ID #:
Secondary Policy Holder's Name:	Secondary Insurance Group #:

Is patient receiving SSI (Supplemental Security Income)? ☐ Yes ☐ No

Is patient receiving Medicaid, CHIP, or FEP/TANF? ☐ Yes ☐ No **If "Yes", skip to Section C below.**

B

Financial Assistance Available: You may be eligible for financial assistance for services provided by Children with Special Health Care Needs. To help us determine your eligibility for assistance, please complete the following information, **and provide your last three consecutive pay check stubs, or most recent IRS tax return (front page is sufficient).**

☐ **I decline to fill out the section below. I understand that by withholding this information, I will not be eligible for financial assistance for services provided and may be liable for all or a portion of the bill.**

Number of Children (If pregnant, include the unborn child)	_____
Number of Adults (Including yourself, spouse and any eligible adults)	_____

→ **Total Family Size**

MONTHLY Gross Income for Family

MONTHLY Gross salary (primary wage earner): Before Taxes, Social Security, Insurance Premiums, Union Dues	$ _____
MONTHLY Gross salary (other wage earner(s)):	$ _____
Other MONTHLY income: Includes pensions, compensations, income from rentals, interest, dividends, alimony or child support, public assistance grants, etc. ***SSI income is NOT included as income***	$ _____
Total Monthly Gross Income*	$ _____

MONTHLY Expenses for Family (Out of pocket)

Medical/Dental Expenses	$ _____
Medical/Dental Premiums	$ _____
Child Support or Alimony	$ _____
Child Day Care Costs	$ _____
Total Monthly Expenses**	$ _____

Shaded area for agency use only

Total Monthly Gross Income*	$ _____	**P**ersonal **F**inancial **R**esponsibility (PFR)	0% 20% 40% 60% 100%	Y N
Total Monthly Expenses**	$ _____			
Total Net Income	$ _____			

C

I understand that my Financial Responsibility will be calculated based on the information I provided above. I understand that I may be liable for all or a portion of the bill and that interest may be charged on accounts unpaid 60 days after billing date.

_____ _____
Print Name of Patient or Legal Representative — Date

_____
Signature of Patient or Legal Representative

☐ Parent of minor child ☐ Self (18 or older)
☐ Medical Power of Attorney ☐ Legal Representative
☐ Other, explain and attach documentation

_____ _____
Name of CSHCN Representative and Date (Please Print)

Note: A new form is required any time there is a change in family size or income.
When completing this form for the Kurt Oscarson Children's Organ Transplant Fund, all sections (A, B, and C) must be completed.

********** Required Information **********

CSHCN Financial Form Worksheet References

Allowable Medical Expenses

Qualifying expenses must be directly related to the health or medical condition of a family member. Expenses must be out of pocket for the previous 12 months and for which you will not be reimbursed by a third party payor.

- Capital expenses for equipment or improvements to your home needed for medical care
- Cost and care of guide animals aiding the blind, deaf, and disabled
- Cost of lead based paint removal
- Expenses of an organ transplant
- Hospital services fees (lab work, therapy, etc.)
- Birth control pills, legal abortion, legal operations
- Meals and lodging provided by a hospital during medical treatment
- Medical and hospital insurance premiums
- Medical services fees (from doctors, dentists, surgeons, specialists and other medical practitioners)
- Oxygen equipment and oxygen
- Prescriptions, medicines, and insulin
- Tutoring recommended by a doctor
- Psychiatric care at a specialty equipped medical center (includes meals and lodging)
- Special items (hearing aids, wheelchairs, etc.)
- Special school, tuition, meals and lodging
- Transportation for medical care
- Treatment at a drug or alcohol center
- Wages for nursing services
- Diaper costs related to medical problem

What cannot be included as expenses:

- Diaper services
- Health club dues
- Household help
- Stop smoking program
- Weight loss program
- Life insurance or income protection policies
- Maternity clothes
- Medicine bought without a prescription
- Nursing care for a healthy baby
- Surgery for purely cosmetic reasons

Note: A new form is required any time there is a change in family size or income.
When completing this form for the Kurt Oscarson Children's Organ Transplant Fund, all sections (A, B, and C) must be completed.