Kosair Charities
Kosair Kids® Program Application
In order to be considered in our next Kosair Kids® committee meeting you must include:

- COMPLETED Application
- Medical Release form
- Two recent pay check stubs from all working parent(s)/guardian(s)
- First two pages of the most recent federal tax return unless additional schedules need to be submitted (rental income, business income, itemized deductions etc.)

  PLEASE REDACT YOUR SSN# FROM YOUR TAX RETURN

- Current bills or quotes
- Letter from physician or recommending doctor stating need or occurrence of medical expenses
- Explanation of Benefits (EOB) stating medical coverage

You must have insurance in order to receive any assistance through Kosair Charities.

*The program is designed to help with medical bills of children 17 years of age and under or still attending high school, whose families cannot otherwise afford to pay.

*If you receive additional bills after you have already submitted your application, mail, e-mail or fax them to Kosair Charities and I will add them to your existing file.

***We are unable to review any charges incurred at Norton's Children's Hospital, formally Kosair Children's Hospital. Please contact Norton Financial Assistance for any Norton bills.**

Kosair Charities
Screening Application

982 Eastern Parkway
P.O. Box 37370
Louisville, KY 40233-7370
502-637-7696
502-637-7698 (fax)

Date_____

Child's Name_____DOB _____

ADDRESS_____PHONE _____

_____
CITY STATE ZIP COUNTY

EMAIL_____Preferred Method of Contact: _____

Is the child a legal U.S. resident? _____ YES _____ NO

Have you applied for assistance with Kosair Charities in the past? _____ YES _____ NO

Child's Diagnosis:_____

Please explain the child's medical diagnosis:

Date of Occurrence: _____

Name of school your child attends (if applicable): _____

Insurance: _____ Deductible amount: $ _____

Has insurance denied these claims? _____ YES _____ NO

***If yes, please include a copy of the denial letter**

Have you applied for Medicaid?_____YES _____NO

If denied, why? _____

Is there a medical trust for the child?_____YES_____NO

Father (Guardian)_____

Employer_____Phone_____

Gross Salary (before taxes) $_____Weekly/BI/Monthly/Annual (Circle One)

Mother (Guardian)_____

Employer_____Phone _____

Gross Salary (before taxes) $_____Weekly/BI/Monthly/Annual (Circle One)

If no income is present, how are expenses paid?

Total HOUSEHOLD Income (before taxes): _____

Family Size_____Marital Status: Single/ Married/ Separated / Divorced/ Widowed

List dependents in household name & age (under 18):

_____ _____

_____ _____

_____ _____

Additional Income **(please provide documentation verifying additional income)**

Child Support	$_____/Monthly
Social Security	$_____/Monthly
Disability	$_____/Monthly
Unemployment	$_____/Monthly
Other (explain):	$_____/Monthly

_____

If unemployment is received, please list the start date: _____

PLEASE DESCRIBE THE CHILD'S MEDICAL EXPENSES THAT REQUIRE ASSISTANCE:

PLEASE DESCRIBE ANY ADDITIONAL INFORMATION REGARDING YOUR CURRENT FINANCIAL SITUATION WE SHOULD BE AWARE OF (SUCH AS FINANCIAL HARDSHIP, SEASONAL OR TEMPORARY INCOME, OR OTHER UNEXPECTED OCCURANCE):

401K/403B: _____ HSA/FSA: _____

MORT. /RENT: _____ CHECKING: _____

CR. CARD BAL: _____ SAVINGS: _____

AUTO LOAN(S): _____ HOME VALUE: _____

CHILD CARE: _____ CAR(S) VALUE: _____

STUDENT LOANS/TUITION: _____ INSURANCE PREMIUMS: _____

OTHER: _____

I,_____, hereby agree to enclose all information and to complete this application honestly and fully. All above information is true and accurate to the best of my knowledge. I understand that in completing this application, Kosair Charities may request additional information necessary to determine my eligibility. If any of the above information is found to be untrue or falsified, I understand my application will be denied and I may be ineligible for future assistance.

Signature:_____Date: _____

*__ANY INCOMPLETE APPLICATIONS WILL NOT BE REVIEWED UNTIL ALL INFORMATION IS RECEIVED__