SPECIALIZED CARE FOR CHILDREN

APPLICATION FOR FINANCIAL ASSISTANCE

CASE NUMBER: _____
OFFICE USE ONLY

1. Child/Youth Information

Legal Name _____ (Last) _____ (First) _____ (Middle)

Birthdate ____ ____ / ____ ____ / ____ ____ ____ ____ (Month) (Day) (Year) Gender: ☐ Male ☐ Female

Street Address _____

City _____ State _____ Zip _____ County _____

Lives in Illinois? ☐ Yes ☐ No
Is a citizen of US? ☐ Yes ☐ No → If no, permanently admitted to the US? ☐ Yes ☐ No

2. Applying Parent or Legal Guardian Information

Legal Name _____ (Last) _____ (First) _____ (Middle)

Relationship: ☐ Father ☐ Mother ☐ Other_____ Birthdate: ____ ____ / ____ ____ / ____ ____ ____ ____ (Month) (Day) (Year)

Phone (___) _____ (Home) (___) _____ (Work) (___) _____ (Cell) (___) _____ (Other)

Social Security # ☐☐☐ – ☐☐ – ☐☐☐☐ OR Individual Tax ID # ☐☐☐ – ☐☐ – ☐☐☐☐

Address: ☐ Check if same as above E-mail Address _____

Street Address _____

City _____ State _____ Zip _____ County _____

Lives in Illinois? ☐ Yes ☐ No
Is a citizen of US? ☐ Yes ☐ No → If no, permanently admitted to the US? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Do You Have Legal Guardianship? ☐ Yes ☐ No, explain _____

3. Other Parent or Legal Guardian Information

Legal Name _____ (Last) _____ (First) _____ (Middle)

Relationship: ☐ Father ☐ Mother ☐ Other_____ Birthdate: ____ ____ / ____ ____ / ____ ____ ____ ____ (Month) (Day) (Year)

Phone (___) _____ (Home) (___) _____ (Work) (___) _____ (Cell) (___) _____ (Other)

Social Security # ☐☐☐ – ☐☐ – ☐☐☐☐ OR Individual Tax ID # ☐☐☐ – ☐☐ – ☐☐☐☐

Address: ☐ Check if same as above E-mail Address _____

Street Address _____

City _____ State _____ Zip _____ County _____

Lives in Illinois? ☐ Yes ☐ No
Is a citizen of US? ☐ Yes ☐ No → If no, permanently admitted to the US? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Do You Have Legal Guardianship? ☐ Yes ☐ No, explain _____

4. Medical Coverage for Child/Youth

☐ All Kids/Medicaid
☐ Health Insurance Policy: Insurance ID # _____ Group # _____

Policy Holder's Name _____ Insurance Company _____
Customer Service Phone _____ ***(If possible, attach a copy of your insurance card)***

(Over - Must Be Signed On Back)

5. Proof of Income (check only ONE box)

Specialized Care for Children uses the Federal Income Tax Return to determine financial eligibility. Other proof may be needed as described below. Mark only ONE of the following boxes and submit the proof of income listed for **you/your spouse, the child in our program and any dependent relatives.**

- ☐ I have filed a current Federal Income Tax Return - Send a copy of your current federal income tax return. (example: 1040, 1040EZ)
- ☐ I have not yet filed a current Federal Income Tax Return - Send a copy of your prior year Federal Income Tax Return. (example: 1040, 1040EZ)
- ☐ I am not required to file a Federal Income Tax Return - Send wage statements (for two [2] pay periods in a row within two [2] months from the date of this application).
- ☐ I am not required to file a Federal Income Tax Return and do not receive wage statements - List the source and amount of your household income: _____

  _____
- ☐ I am enrolled in the Illinois Hemophilia Program - Send a copy of your Illinois Hemophilia Program eligibility Letter. You may also send a current tax form to see if you are eligible for financial help up to two (2) years.

6. Additional Financial Information (complete ONLY if applicable)

If your family had a permanent job loss, divorce, death of spouse or you and your spouse are living in separate households since the period covered by the Tax Return submitted with this application - explain the event including the date it occurred: _____

_____

7. Total Family Size

Please list **yourself, your spouse, ALL children** and **any other members of your household** that you financially support. (Attach additional sheet if needed)

Name (first, middle initial and last)	Relationship (e.g., son, daughter, stepchild, grandparent)	Birthdate	OFFICE USE ONLY
			☐
			☐
			☐
			☐
			☐
			☐
			☐

Total Family Size _____

Initials _____

8. Is there any legal action regarding medical care for the applying child/youth? ☐ Yes ☐ No

9. Financial Information Certification *(please read and sign)*

I understand that providing false information can result in immediate loss of any financial assistance provided by Specialized Care for Children and legal action to recover any amounts previously paid by Specialized Care for Children.

(check only ONE box for each signature)

_____ Signature of Applying Parent or Legal Guardian	☐ Proof of Income Submitted	or	☐ No Income Received	_____ Date
_____ Signature of Applying Parent or Legal Guardian's Spouse	☐ Proof of Income Submitted	or	☐ No Income Received	_____ Date
_____ Signature of Child in Our Program (16 years and older)	☐ Proof of Income Submitted	or	☐ No Income Received	_____ Date