Stanford Children's Health | Lucile Packard Children's Hospital Stanford

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 of 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 and 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: '

LPCH Patient Financial Advocacy
4700 Bohannon Drive, 2nd Floor
Menlo Park, CA 94025
Phone: (650) 498-7003 **Fax: (650) 497-8610**
Email: PFA@Stanfordchildrens.org

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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: ☐ Parent ☐ Other				
MARITAL STATUS: ☐ Married/Domestic Partner ☐ Divorced ☐ Separated ☐ 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 ☐ Parent ☐ 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			
Monthly Income Sources	**Applicant (Parent or Legal Guardian)**	**Co-Applicant (Other Parent or Legal Guardian)**	**Combined Monthly Income**
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			
Checking/Money Market/Savings Accounts:		******List all available funds**	
Bank Name:	**Branch/Address**	**Account Number**	**Current Balance**
1.			$
2.			$
3.			$

6. ESTIMATED MONTHLY LIVING EXPENSES			
Monthly Expenses	**Monthly Payment**	**Monthly Expenses**	**Monthly Payment**
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)	$	List Other Monthly Payments	$
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 and 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:

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