

**ARIZONA DEPARTMENT OF HEALTH SERVICES
High Risk Perinatal Program / Newborn Intensive Care Program
Financial Worksheet & Questionnaire**

Place Required Label Here
(If label will not fit, place
on the back of the form)

1. Infant's Last Name	2. Suffix	3. First Name	4. MI	5. DOB
6. Last Name (Responsible Person)	7. Suffix	8. First Name	9. MI	10. DOB
11. Insured Last Name	12. Suffix	13. First Name	14. MI	
15. Infant's Insurance Coverage Type <input type="checkbox"/> 3 rd Party Private <input type="checkbox"/> AHCCCS <input type="checkbox"/> KidsCare <input type="checkbox"/> IHS non-AHCCCS <input type="checkbox"/> None		16. Infant's AHCCCS Status <input type="checkbox"/> Eligible <input type="checkbox"/> Ineligible <input type="checkbox"/> Pending <input type="checkbox"/> Refused		
17. Infant's AHCCCS #		18. Infant's AHCCCS Eligibility Date		

Do include current income of both parents prior to any tax or other deductions. Include mother's income if she will be returning to work after maternity leave. Include ALL sources of parental income.*

DETERMINATION OF FAMILY LIABILITY

A. Household Size
Include newborn(s), parent(s), siblings & any dependent(s) claimed on latest tax forms.

GROSS ANNUAL HOUSEHOLD INCOME

Father's _____
Mother's _____
Other _____
B. Total **Gross** Household Income*
\$ _____

*Include income of both parents, if working. Do not include income of other family members such as grandparents, unless they are assuming financial responsibility for the baby.

Medical expenses are defined as medical, vision and dental expenses, including insurance premiums, incurred from the infant's date of birth and 12 months prior. **Do not** include expenses paid or expected to be paid by any third party insurance payer. **Do not** include current charges for infant's stay in the intensive care unit. **DO** include mother's prenatal care, **mother's hospital charges** and baby's hospital charges before transported (if not enrolled in NICP at that hospital).

Medical, Dentist, and Vision insurance premiums (Deducted from paycheck or direct pay)	_____
Doctor, Dentist, and Vision co-pays, deductibles and charges	_____
Prescriptions	_____
Lab and other medical testing charges	_____
Vision Care (glasses/contact lenses)	_____
Medical Supplies	_____
Surgery Charges	_____
Other medical expenses	_____
Total Medical Expenses	_____
B. Total Gross Household Income \$	_____
C. Less Total Medical Expenses \$	_____
D. Adjusted Gross Income (B minus C) \$	_____
E. NICP Family Liability taken from the ADHS Family Liability Table (Use A and D above) \$	_____

I hereby request financial assistance for payment of expenses for transport and/or care in the hospital intensive or intermediate care centers in accordance with the policies of the Arizona Department of Health Services (ADHS). I agree to enroll my infant on my third party and/or AHCCCS plan, if eligible, within thirty (30) days from infant's date of birth, and understand that failure to do so will result in denial of NICP financial assistance. I shall assist all providers to obtain 3rd party payments. I have completed the NICP Financial Worksheet & Questionnaire, and will receive a copy from the hospital representative after signing below. I understand that financial assistance is not available for out-of-state hospital, out-of-state physician care, or care through non-contracted hospitals. **I understand that if my Household Income changes during the first 60 days from my infant's date of birth, I may contact the hospital interviewer to complete a revised financial questionnaire. Any revisions must be received by ADHS within 90 days from infant's date of birth.**

Signature of Parent / Guardian / Responsible Person

Relationship to Patient

Date

Signature of Hospital Interviewer

Printed Name of Interviewer

Date

Interviewer Comments _____