Financial Eligibility Statement (renewal)

The W. Paul Biggers MD
Carolina Children's Communicative Disorders Program
5501 Fortunes Ridge Dr. Suite A
Durham, NC 27713
Phone: 919-419-1449 / Fax: 919-419-1399

For your child to be considered for re-enrollment in the CCCDP Grant Program, this form must be completed in full. This confidential information will be kept private. It is only used to determine eligibility for the program. All questions must be answered to the best of your ability, and the form signed by an adult (parent or guarantor). ALSO your most recent **Federal Tax Forms IRS 1040 and NC State Tax Form D-400**, must be submitted. If they are long, just send in the first two pages of each. If you have not filed tax returns for last year, please contact us.

Demographics

Child's Name: _____ DOB: _____
UNC Medical Record Number (MRN): _____ SSN: _____
2nd Child's Name: _____ DOB: _____
UNC Medical Record Number (MRN): _____ SSN: _____
Parent #1 Name: _____ DOB: _____
Parent #2 Name: _____ DOB: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone(s): _____
Email Address(es): _____
Guarantor Name: _____ DOB: _____
Guarantor Marital Status: _____ Does the child live with the Guarator? Yes ☐ No ☐

Employment

Parent #1 Employer: _____ How long? _____
Job Title: _____ Phone: _____
Parent #2 Employer: _____ How long? _____
Job Title: _____ Phone: _____

Family

Number of persons in household (dependents), including parents: _____
Name of sibling #1: _____ Age: _____
Name of sibling #2: _____ Age: _____
Name of sibling #3: _____ Age: _____
Name of sibling #4: _____ Age: _____

Annual Income

Parent #1 Income: _____
Parent #2 Income: _____
Other annual income (explain): _____
Miscellaneous or one-time income (explain): _____
TOTAL ANNUAL INCOME: _____

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Home & Real Estate

Do you own or rent your home? Own: ☐ Rent: ☐
Mortgage balance: _____ Lender: _____
Do you own other real estate: Yes: ☐ No: ☐
If yes, describe: _____

Annual Expenses

Rent or mortgage (monthly _____ x 12) Total: _____
Utilities (power, water, internet, phones): _____
Vehicle maintenance and fees per year: _____
Medical expenses (in last year): _____
Medical debt payment (_____ x 12) Total: _____
Medical debt balance still owed: _____

Medical Insurance

Medical insurance premiums per year: _____
Medical insurance deductible per year: _____
Name of Company: _____
Subscriber Name: _____
Is child covered? Yes ☐ No ☐ Policy #: _____

Comments **(Any other information that you would like to provide about financial need)**

_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

By signing this form you certify that the answers provided above are true to the best of your knowledge. You also understand that fraudulent or misleading information will make you ineligible for any financial assistance. We reserve the right to contact your employer or other holders of financial information.

Please direct all questions related to this application to
Velma Grose at velma.grose@unchealth.unc.edu
Phone: (919) 419-1449