HEART OF TEXAS HEALTHCARE SYSTEM
Financial Assistance Policy
Application Check List

1. Application
2. Expense Questionnaire
3. Financial Statement
4. Copy of Driver's License or Picture I.D.
5. Copy of Social Security Card or Resident Alien Card
6. Verification of Deposit – Checking and Savings Accounts (Last three Bank Statements)
7. Verification of Residence (Utility Bills both water and light bill)
8. Last Year's Income Tax Return and account of all contributors to the household income
9. Proof of Worker's Compensation benefits
10. Proof of income (check stubs for past 6 months)
11. Proof of unemployment benefits
12. If self-employed: Proof of year to date income and expenses
13. If no income: Signed statement from head of household
14. If on Social Security or SSI Benefits: End of year letter from Social Security stating amount of benefits. (If applicant does not have a copy of this letter, they should call the Social Security office in San Angelo.)
15. If separated from Spouse: Affidavit of fact (A request for an additional affidavit from a witness may be made.)
16. Medicaid Denial letter/certification letter if applicable

HEART OF TEXAS HEALTHCARE SYSTEM
APPLICATION FOR FINANCIAL ASSISTANCE

Appointment Date: _____ Time: _____

1. Patient _____ Date of Request ___/___/___
   First Middle Last
   Parent/Guardian: _____
   (if patient is minor child)
   Address: _____
   Mailing Address City State Zip Code
   Home Telephone (____)_____-_____ Work Telephone (____)____-_____

2. Occupation: _____ Employer: _____

	Last 3 Months	Last 12 Months
3. Earnings	$_____	$_____
Self – employment earnings	$_____	$_____
Military Family Allotments	$_____	$_____
Public Assistance	$_____	$_____
Child Support	$_____	$_____
Pensions	$_____	$_____
Social Security/SSI	$_____	$_____
Unemployment Compensation	$_____	$_____
Workers Compensation	$_____	$_____
Income from Dividends, Interest, Rent	$_____	$_____
Alimony	$_____	$_____
Other Benefits	$_____	$_____
Projected 12 months income	$_____	

4. Liquid Assets:

Cash, Checking, and Savings Accounts	$_____
Certificates of deposit	$_____
Mutual Funds, stocks, bonds	$_____
Other investments	$_____
Cash surrender value	$_____

Note: Heart of Texas Healthcare System will not review eligibility until verification (Income Tax Returns, Quarterly Tax Reports, Bank Statements, etc.), is provided by the applicant. (Eligibility is based on the lesser amount of projected twelve (12) month income or actual income of last twelve (12) months.)

5. List the number of household members and those who contribute income: Include the number of dependents to whom you provide more than one-half support.

Name	AGE	RELATIONSHIP

6. Hospital services for which Financial Assistance is requested:

Inpatient	Date(s) of Service: _____
Emergency services	Date(s) of Service: _____
Outpatient services	Date(s) of Service: _____
Other	Date(s) of Service: _____

7. Complete this section only when determining medical indigence.

EXPENSE STATEMENT:

MONTHLY EXPENSES:

Monthly rent or mortgage payment	$_____
Tax on home	$_____
Monthly Utilities (gas, electric, propane etc.)	$_____
Cable TV	$_____
Telephone	$_____

Loan Payments:

Automobile (Make/Model) _____	$_____
Automobile (Make/Model) _____	$_____
_____	$_____
_____	$_____

Charge Accounts:

_____	$_____
_____	$_____
_____	$_____

Furniture/appliance payments	$_____
Transportation (fuel etc.)	$_____
Insurance (home, life, auto)	$_____
Medical cost (bills, medicine, insurance, transportation, home care etc.)	$_____
Child care or care for a family member at home	$_____

Legally obligated child support payments $_____
Legally obligated alimony payments $_____

Subtotal $_____

Does anyone else pay or assist in paying these expenses for you? _____Yes _____No
If yes, how much? (Subtract from expenses) $_____

(Subtract)

Total $_____

Did the applicant have any other unpaid medical bills during the last 12 months? _____Yes ____No

Unpaid balance after third party payment(s) $_____

Gross Annual Income $_____

% of unpaid medical bills to gross annual income _____%

Patient//Guardian Attestation

As provided for in federal law, I hereby request that Heart of Texas Healthcare System make a written determination for my eligibility for uncompensated services at Heart of Texas Healthcare System. I understand that the information that I submit concerning my annual income and family size is subject to verification by Heart of Texas Healthcare System. I also understand that if the information which I submit is determined to be false such a determination will result in denial of providing services as uncompensated services.

_____ _____/_____/_____
Signature Date

_____
Printed Name

Reviewed by: _____
HOTHS Financial Services Representative