HEART OF TEXAS
HEALTHCARESYSTEM
2008 Nine Road • Brady TX 76825-1150 • 325.597.2901

To Whom It May Concern:

Enclosed you will find a financial assistance application to determine if you are eligible for help with your medical bills through the Financial Assistance Program offered by Heart of Texas Health Care System. Please supply the information requested, along with a completed application that has been enclosed. Be sure to complete the form in its entirety and return all completed documentation. Without the requested information, we are unable to determine your eligibility and account balances will become your responsibility and could be reviewed for collections if not resolved. **If you have a Primary Insurance, Deductibles and/or Copays WILL NOT BE COVERED by the Financial Assistance Program.** You may be contacted in regard to applying to Medicaid/Medicare during the application review process.

Requested Documentation:

- Expense Questionnaire
- Financial Statement
- Copy of Driver's License or Picture I.D.
- Copy of Social Security Card or Resident Alien Card
- Verification of Deposit- Checking and Savings Account Statements for the Last 3 Months
- Verification of Residence- Utility/Electric Bill Statement
- Previous Years Income Tax Return and account of all contributors to the household income
- Proof of Workers Compensation benefits- if applicable
- Proof of Income for the last 6 months
- Proof of Unemployment benefits- if applicable
- If Self-employed: Proof of year to date income and expenses
- If no Income: Signed statement from head of household
- If on Social Security of SSI Benefits: End of year letter for Social Security stating amount of benefits
- If separated from spouse: Affidavit of fact
- Medicaid Denial Letter/Certification letter- if applicable

Please send/bring requested information to:

Heart of Texas Health Care System
Attn: Business Office
2008 Nine Rd
Brady, Tx 76825
(325) 792-3930

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