Martin County Hospital District
Financial Assistance Application

Patient Name | Patient Account Number

Telephone Number | Social Security Number | Birth Date (Month/Day/Year)

Mailing Address City State Zip a Employed D Unemployed

Employer (Name, Address and Telephone Number)

Spouse Name | Social Security Number | Birth Date (Month/Day/Year)

Patient's Father (If patient is a minor) | Social Security Number | Birth Date (Month/Day/Year)

Patient's Mother (If patient is a minor) | Social Security Number | Birth Date (Month/Day/Year)

A. Wages & Other Resources: Please provide the annual income for your household spouse, life partner, others contributing to income. Total Checking & Savings Balance; Please provide the combines total amount of checking and savings accounts available to you and other household members, Yearly Income, Other Resources: stocks, bonds, trust funds, royalties, etc. along with the yearly income you receive from these other resources, including interest income, dividends, and rental income.

$_____ Yearly Household Income

$_____ Yearly Income, Other resources

$_____ Total Checking & Savings Account Balance

$_____

B. Household Members: Please provide the number of persons in the patient's household. _____

Do you own a home? (circle one) Yes ☐ No ☐ If yes, provide value of home: $_____

Do you rent? (circle one) Yes ☐ No ☐ If yes, monthly rent amount: $

C. Taxes:

Did you file a tax return for the last tax year? (Circle One) Yes ☐ No ☐

Can you be claimed as a dependent on someone else's taxes this year or the prior year? If yes please provide (Circle One) Yes ☐ No ☐

D. Income Verification: Please provide ALL of the following documents to verify household income.

IRS Form W-2 • Employer Verification

Paycheck Remittance • Proof of Participation in Governmental Assistance programs such as food stamps, CDIC, Medicaid or AFDC

• Tax Return Social Security or Unemployment Compensation Determination Letters Bank Statements • Other, Please Describe

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

_____

I understand Hospital may verify the financial information contained in this Financial Assistance Application ("Application") in connection with Hospital's evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize Hospital to request reports from credit reporting agencies and the Social Security Administration. I certify that this information is true to the best of my knowledge and I am aware that falsification of information on this Application may result in denial of financial assistance. I understand and will provide any outstanding supporting documents within 30 days of my signature below.

Date

_____

Signature of Patient or Responsible Party

Date

_____

Hospital Approval /Title

Dear Patient:

As part of our commitment to serve the community, Martin County Hospital elects to provide financial assistance to individuals who satisfy certain income requirements.

To determine if a person may qualify for financial assistance, we need to obtain certain financial information as outlined within this application. Your cooperation will allow us to give consideration to your request for financial assistance.

Please complete the Financial Assistance Application and return the completed form to the Financial Eligibility Office, or the completed form may be mailed to the following address:

Martin County Hospital District
ATTN: Financial Assistance Program
PO Box 640
Stanton, Texas 79782

You will continue to receive statements and attempts to collect this debt will continue until such time that the application is approved for assistance.

Below please find the instructions for completing the financial application. Should you need assistance in completing the form, feel free to contact us at (432) 607-3618.

Any consideration or potential approval of assistance applies ONLY to services provided by Midland Memorial Hospital and is not related or applied any way to any physician bills whether by your attending physician or any consulting, pathologist, radiologist or any other physician which may be involved in your cave.

Section A: Wages & Other Resources

In Section A of the Financial Assistance Application, please indicate the Dollar Amount each listed person receives as compensation and whether the amount represents hourly, weekly, monthly, or yearly compensation. Persons in the household include patient, spouse, or others contributing to the household income. In the last part of Section A of the Financial Assistance Application, please indicate the Dollar Amount you have invested in checking accounts, savings accounts, stocks, trust funds etc. In the second blank please indicate the Dollar Amount of income you receive yearly from such investments. For example, in the first blank one might put that they have $5,000 in a savings account and in the second blank they might put that they earn $250 interest yearly on that account.

Section C: Household Members

Section C of the Financial Assistance Application requests information on the number of persons in the patient's household. This number should include the patient, the patient's spouse and the patient's dependents or any other person living in the household providing any support. If the patient is a minor, please include the patient, the patient's mother and/or father and/or legal guardian and any Resident Dependents of the patient's mother and/or father, and/or Legal Guardian and/or significant other.

Section D: Income Verification

In order to consider your request for financial assistance, verification of the wages reported in Section A of the Financial Assistance Application is required. Please provide a copy of an IRS Form W-2, Wages and Tax Statement; pay check remittance; tax return; bank statement or other appropriate indicator of income. or proof of participation in a public benefit program such as Social Security, Unemployment Compensation, Medicaid, County Indigent Health Program, AFDC, Unemployment Insurance, Food Stamps, WIC, or other similar indigence related programs.

You are unable to provide one of the sources of income documentation listed above, please provide a written explanation in Section D of the Financial Assistance Application.

For assistance in completing this application, please contact us at (432) 607-3618, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.