Trinity Regional Hospital Sachse

APPLICATION FOR FINANCIAL ASSISTANCE

To apply for financial assistance, on the bill from Trinity Regional Hospital Sachse, complete this application, sign your name, and return the application to the Financial Counselor within 30 days of your visit. Contact the Financial Counselor at (469)- 962-2100 if you need help completing the application.

PERSONAL INFORMATION

Name: (Please Print)	Name and Social Security Number of Patient (if different from person completing application):
Home Phone #:	Work Phone#:
Address:	City/State/Zip Code:
What County do you live in?	Is Address Permanent or Temporary?

HOUSEHOLD MEMBERS AND MONTHLY INCOME

Name of Household Members	Relationship to Household Member	Age & Date of Birth	Monthly Gross Income	Monthly Welfare/ Child Support	Monthly Pensions, Retirement, Social Security	Any Other Monthly Income

INCOME VERIFICATION

Please provide any of the following types of documentation to verify your income. (This information will be used solely for the purpose of assessing eligibility for medical assistance.)	
IRS Form W-2, Wage and Earnings Statement Paycheck Remittance, 1099 IRS Form	Bank Statement/Records
Individual Tax Return	Government Program Statements
Social Security, Work Comp or Unemployment Comp letter	Telephone verification by employer
Physician Disability Statement	Patient deceased
Other	
If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:	
Other Resources: Please provide the total amount of other resources available to you, including such things as savings accounts, checking accounts, stocks, bonds, etc.: $___________________________	

MONTHLY EXPENSES

Rent/Mortgage payment		Car/Truck Payment	
Electric and/or Gas Payment		Child Care Expenses	
Telephone/ Cell Phone		Loans	
Cable/Satellite		Other: Water/Auto Insurance	

SIGNATURE AND SOCIAL SECURITY NUMBER:

I certify that all of the above is true and correct and that all income is reported. I understand that this information is being given for the determination of FINANCIAL ASSISTANCE for services rendered at Trinity Regional Hospital Sachse; and that hospital officials may verify the information on the application. I understand that deliberate misrepresentation of the information may subject me to immediate denial.

X ____________________________________ X____

SIGNATURE OF ADULT HOUSEHOLD MEMBER SOCIAL SECURITY NUMBER

DO NOT WRITE BELOW THIS LINE — FOR HOSPITAL USE ONLY
(Monthly income conversion: weekly x 4.33, Every 2 weeks x 2.15, Twice a Month x 2)
(Yearly income conversion: monthly x 12)

Total Household Size:	Monthly Income:	Yearly Income:
Food Stamps: Y / N		
Eligibility Determination: Approved	Denied	Pending
Reason for Denial: Income too much	Incomplete Information	Other
Account This Application Applies To:	Patient:	
Signature of Determining Official:	Date:	
	Other:	
Reason applicant did not complete application (if applicable):		
Reason verbal attestation of income necessary (if applicable)		

FINANCIAL ASSISTANCE APPROVAL WORKSHEET
Office Use Only

Name: ___________________________________ Patient Account Number: ___________________

Date of Birth: _____________________________ Social Security Number: ____________________

Gross Annual Household Income: $__________ Total Charges: $___________________________

Number in Household: _____________________ Account Balance: $________________________

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Circle type of documentation or income verification provided:

IRS Form W-2, Wage & Earnings Statement	Telephone Verification by Employer
Paycheck Remittance	Bank Statement/Records
Individual Tax Return	Physician Disability Statement
IRS Form 1099	Written Attestation (Patient signed Assistance Application verifying Total Yearly Income)
Social Security, Work Comp or Unemployment Comp Letter	Verbal Attestation (Patient Verbally verified Total Yearly Income)
Government Program Statement	Patient Deceased

Circle appropriate answer in response to the following questions:

1. Is Total Gross Annual Income equal to or less than 200% of the Federal Poverty Guidelines?

   YES Approved for 100% financial assistance as Financially Indigent.

   NO Patient does not qualify for assistance as Financially Indigent. Continue to Step 2.

2. Is balance due after payment by all third party payors equal to or greater than 10% of Total Yearly Income?

   YES Patient qualifies as Medically Indigent. Refer to Hospital Financial Assistance Eligibility Discount Guidelines — Attachment A for amount of discount.

Medically Indigent
Total Yearly Household Income is less than ______________________% of the Federal Poverty Guidelines. Approved for ____________________________% discount.

OR

Catastrophic Medically Indigent
Balance due is ________% of the total yearly income. Approved for _____% discount.

NO Patient does not qualify for Financial Assistance.