



Dear Patient/Responsible Party,

We are providing this application because you may qualify for our ***Financial Assistance Program***.

To be eligible for the program, you must have applied for Medicaid, State or Local Assistance and have been denied, because you do not meet the requirement for an application.

The attached form only applies to hospital bills, and does not include any other medical bills you may have; such as physician, radiology, ambulance, etc.

In order to be considered for a full or partial assistance, you **must** complete the Financial Assistance Application. The responsible party **must sign** the bottom, and return the completed application within fourteen (14) days of receipt.

Inpatient Visits: If you were admitted into the hospital as an inpatient, it is necessary for you to provide us with **your latest Federal Tax Return** for supporting documentation. If you did not file a tax return, please indicate and attach any two of the documents listed below.

State Income Tax Return
Employer Pay Stubs
Written documentation from income sources
Copies of all bank statements for the past three months

Medicare Patients: If you are covered by Medicare, it is necessary for you to provide us with **your latest Federal Tax Return** for supporting documentation. If you did not file a tax return or were not required to file a tax return, per federal guidelines, please provide the documents listed below.

Supporting W-2
Supporting 1099's
Most recent bank and broker statements
Qualified Medicare Benefits

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.

Please allow ten (10) business days for our review process. We will notify you of our charity determination by letter.

**Remember if you return this form your bill may be
included in our Financial Assistance Program.**

**Mail application and all required documents to:
HCA Patient Account Services
Attn: Research and Correspondence Dept
10030 MacArthur Blvd.
Irving, TX 75063**

FINANCIAL ASSISTANCE APPLICATION

Hospital Name _____ Account Number _____
 Patient Name _____ Social Security Number _____
 Responsible Party Name _____ Social Security Number _____
 Address _____ Phone Number _____
 Are you a US Citizen? _____ What state do you reside in? _____

Dependents in Household

(This includes spouse, children under 18 and all others claimed on your tax return)

Name	Age
(First, Middle and Last Name if different than Patient)	
_____	_____
_____	_____
_____	_____

Employment (Patient/Responsible Party)

Employer Name _____ Hourly Rate _____ Hours Worked Per Week _____
 Current Gross Weekly, Monthly or Yearly Income (Before Taxes) _____
 If unemployed, date last worked _____

Spouse Employment

Employer Name _____ Hourly Rate _____ Hours Worked Per Week _____
 Current Gross Weekly, Monthly or Yearly Income (Before Taxes) _____
 If unemployed, date last worked _____

Other Income

	Patient	Spouse
Social Security		
Pension		
Unemployment		
Worker's Compensation		
VA Benefits		
Rental Income		
Stocks, Bond, 401K		
Dividend/Interest		
Child Support		
Alimony		
Other		

Have you applied for Medicaid or any other State/County Assistance? _____
 If yes and known, Case Number _____ Date Applied _____

I, the undersigned, certify that I am eligible for financial assistance because I am the person responsible for payment of amounts that may be due because of services provided. I further certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application and to assist in determining whether I am qualified for financial assistance. I understand that falsification of information or failure to complete all fields submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to help pay this hospital bill prior to completing this application.

Signature _____ Date _____

Mail to: HCA Patient Account Services, Research & Correspondence Dept, 10030 MacArthur Blvd, Irving, TX 75063