Harris County ESD 11 Mobile Healthcare
18334 Stuebner Airline Road
Spring, TX 77379

Charity Care / Financial Assistance Form - *Confidential*

Applicant Information

Patient

Full Name: _____ Account No: _____
Last First MI

Address: _____
Street Apartment / Unit No.

_____
City State Zip Code

Phone: _____ Email: _____

Male / Female / Other Birth Date: _____ SS No. _____

Guarantor

Full Name: _____
Last First MI

Address: _____
Street Apartment / Unit No.

_____
City State Zip Code

Phone: _____ Email: _____

Birth Date: _____ SS No. _____

Is the patient currently homeless? YES ☐ NO ☐

Has the patient applied for Medicaid? YES ☐ NO ☐ If yes, when? _____

Do you need an interpreter? YES ☐ NO ☐ If yes, list preferred language _____

Harris County ESD 11 Mobile Healthcare
18334 Stuebner Airline Road
Spring, TX 77379

Charity Care / Financial Assistance Form - *Confidential*

Family Information

Name				
Date of Birth				
Relationship to Patient				
If 18 years or older; Employer name or Source of income				
If 18 years or older; Total gross income (before taxes)				
Also applying for financial assistance?				

All adult family members' income must be disclosed, add additional pages if necessary.
Sources of income include, but aren't limited to:
Wages, Unemployment, Self-employment, Worker's compensation, Disability, SSI, Child Support, Work study program (students), Retirement account distributions, Other (please explain) _____
_____

Income Information

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.

Examples of proof of income include:

- A "W-2" withholding statement; or

Harris County ESD 11 Mobile Healthcare
18334 Stuebner Airline Road
Spring, TX 77379

Charity Care / Financial Assistance Form - *Confidential*

- Current pay stubs (3 months); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

Asset Information

This information may be used if your income is above 200% of the Federal Poverty Guidelines

Current checking account balance

$_____

Current savings account balance

$_____

Please check all that apply.

Does your family have these other assets? Stocks ☐ Bonds ☐ 401K ☐ Health Savings ☐
Trust ☐ Property ☐ Own a business ☐

Additional Information

Please attach an additional page if there is other information about your current financial situation that you would like us to consider, such as financial hardship, excessive medical expenses, seasonal or temporary income, or personal lost.

Patient Agreement

I understand that Harris County ESD 11 may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services rendered.

Signature: _____ Date: _____