

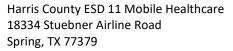


Charity Care / Financial Assistance Form - Confidential

Applicant Information

<u>Patient</u>						
Full Name:				Acc	Account No:	
	Last	First		MI		
Address:						
	Street				Apartment / Unit No.	
	City			State	Zip Code	
Phone:			_ Email:			
Male / Female	e / 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 patier	nt applied for Medicaid?	YES	NO If yes, wh	en?		
Do you need a	an interpreter?	YES	NO If yes, list	preferred lang	guage	

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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?		
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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

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

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- 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.

4	sset Information
This information may be used if your income	e 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
Ado	litional Information
	other information about your current financial situation that cial hardship, excessive medical expenses, seasonal or
P	atient Agreement
·	verify information by reviewing credit information and assist in determining eligibility for financial assistance or
	nd correct to the best of my knowledge. I understand if the be false, the result may be denial of financial assistance, and y for services rendered.
Signature:	Date:

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