HENDRICK
Medical Center

PLEASE READ CAREFULLY

Enclosed is an application from Hendrick Medical Center for assistance with your hospital services only.

Please fill out this form completely and precisely and return it to us in the self-addressed postage paid envelope that we have provided. The application(s) will help us in determining the discount amount you may qualify for.

Please **do not leave any blanks unanswered on the form.** If some questions do not apply to you or your situation, **please indicate with N/A (not-applicable) not a 0 (zero).**

Our guidelines require:

- Hard copy of two current pay stubs. Direct deposit is not acceptable.
- The prior year complete tax return. If you applied for an extension we need a letter of extension.
- Last two months of complete bank statements (all pages) of any open bank accounts (joint and/or individual of checking and savings).
- If there is not a checking account and pay check is being direct deposited to a debit or pay card a copy of the card is required.

If the applicant has no checking or savings account, please indicate that by putting NONE in the proper space. **Do not put a zero (0). The application will not be processed.** If you no longer file a tax return please indicate that on the form. Additional Information may be requested once the application is reviewed. Failure to provide any of the required information or to leave unanswered questions on the form could result in a denial of assistance.

Sincerely,
Patient Resource Assistance Dept.
325-670-4160
Hendrick Medical Center
1900 Pine Street
Abilene, Texas 79601

MRN_____

HENDRICK HEALTH SYSTEM
REQUEST FOR ASSISTANCE

Patient Name_____ Phone_____

Social Security #_____ DOB_____

Address_____ City_____ State_____ Zip_____

List of family members in the home: _____

NAME	SOCIAL SECURITY	RELATIONSHIP TO PATIENT	DOB	AGE

Guarantor on account: _____ Address_____ Phone_____

Do you have health insurance?_____ Are the minors on Medicaid and/or Chip? _____

Have you applied for: CIHCP_____ Medicaid_____ Other_____

If you have applied, please give details_____

FINANCIAL INFORMATION

INCOME (*Attach Proof of Income*-Application cannot be processed without income)

Name of wage earner:	Place of Employment	Length of Employment	Estimated monthly income
			$_____
			$_____
			$_____

Other Income Source (SSI/SSD, Disability, Social Security Retirement, Other Retirement, VA Pension, Rental Property, Workers Comp, Unemployment, child support, etc.)

_____ $_____

_____ $_____

If no income, how do you meet your living expenses:

_____

_____

CASH AND ASSETS (ATTACH COMPLETE BANK/SAVINGS STATEMENTS)

Checking Balance $_____ Savings Balance $_____

Cash Surrender Value of Life Ins $_____

Current Cash Value of Other Liquid Assets: (Stocks, Bonds, CD's, Mutual Funds, etc.) $_____

Auto (1) Year/Make_____

Auto (2) Year/Make_____

Own/Rent Home: _____ Other Property Owned: _____

EXPLAIN CIRCUMSTANCES IN WHICH PAYING THIS HOSPITAL BILL WOULD CREATE A HARDSHIP_____

_____

_____

_____

I certify the above information is accurate & complete. I authorize Hendrick Medical Center to contact employers and to investigate my credit record.

Signature:_____ **Date**_____

Assisted by HMC Rep:_____ **Date**_____

HENDRICK HEALTH

Date_____

RE: _____

MR: _____

DISCLOSURE OF PHI (PROTECTED HEALTH INFORMATION)

To Whom It May Concern:

_____I am the above patient and I authorize Hendrick Medical Center to discuss and obtain financial information necessary for payment or financial assistance, which may include the disclosure of my protected health information (PHI), with the following person (s):

Name_____Relationship_____

Name_____Relationship_____

Signature_____Date_____

EMERGENCY CONTACT INFORMATION

NAME_____Phone_____

Address_____City, St._____Zip_____

NAME_____Phone_____

Address_____City, St_____Zip_____