REQUESTED DOCUMENTS

PROOF OF INCOME AND RESOURCES

You must provide copies of the following information with your application. Failure to do so will result in a delay or possible denial of your application.

1. Proof of identity…**current driver's license**, DPS ID card, voter's registration card, alien registration card or temporary resident card.

2. **Social Security numbers/cards** for everyone in you household.

3. **Most recent checking**, savings and credit union statement.

4. Verification of stock, bonds, notes or CD's.

5. At least **four of your most recent check stubs** or an employment verification form completed by your employer.

6. Award letters or verification of other income such as **Social Security, SSI**, unemployment, worker compensation, retirement and child support.

7. Rent receipts or mortgage receipts.

8. Car payment receipts.

9. **Utilities receipts**

10. **Any other monthly expense receipts** _(i.e. unpaid medical bills, prescription drug receipts, daycare expenses, grocery, gas receipts, tuition,etc.

Methodist
HEALTH SYSTEM

Application for Hospital Charity Assistance

PLEASE PRINT CLEARLY

Applicant's Name (Last, First, Middle)	Home Phone Number	Cell Phone Number	Work Phone Number
Mailing Address (Street, P.O. Box, or RFD)	City	State	Zip
Home Address (if different from Mailing Address)			
Check the kind(s) of Medical Assistance that you need: ☐ County Indigent Health Care (CIHCP) ☐ Maternal and Infant Health Care (MIHIA) ☐ Primary Health Care			

☐ I need medical care and cannot pay for it.

☐ I have medical bills that I cannot pay.

☐ I am pregnant and have been referred.

Who referred you?

☐ Doctor ☐ Public Health Clinic ☐ Community Health Center ☐ Certified Nurse Midwife

☐ Social Worker ☐ Facility (hospital) ☐ Other (specify): ☐ Lay Midwife

ANSWER EVERY QUESTION. Write "NA" if the question does not apply. This application should be completed by or for the applicant.

1. Fill in all blanks for everyone who lives with you, whether you consider them household members or not.

NAME (Last, First, Middle)	WHAT KIN TO YOU	DATE OF BIRTH (Mo. Day Yr.)	SEX	RACE*	MARRIED Yes	MARRIED No	IN SCHOOL Yes	IN SCHOOL No	SOCIAL SECURITY #
(a)	SELF								
(b)									
(c)									
(d)									
(e)									
(f)									
(g)									
(h)									
(i)									

* Information on race is voluntary and is requested to ensure that benefits are provided without regard to race, color, or national origin. It will not affect your eligibility or benefit level.

2. Give your household's county and state of residence (where you make your home)..... | County | State |

3. Do all the listed people who want Medical Assistance plan to stay in this country and state as residents?..... ☐ Yes ☐ No

4. Does anyone who lives with you receive benefits from (check "Yes" or "No" for each type of program):

AFDC	SSI	Food Stamps	Social Security	Medicaid	WIC
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

5. Do you or anyone who lives with you have a job (including day work, babysitting, etc.) or are any of you in training for a job?....☐ Yes ☐ No
If "Yes", fill out the blanks for each person who is in training or is employed (including self-employment):

Give Names of People Who are WORKING or in TRAINING	Give Name and Address of Employer of Where Training is Provided	Number Hours Per Week		How Often Paid?					Gross Pay (Before Deductions)
		Regular	Overtime	*1	*2	*3	*4	*5	

*1 = Daily *2 = Weekly *3 = Every Two Weeks *4 = Twice Monthly *5 = Monthly

6. Do you or anyone else in your household receive money from the following sources? (check "Yes" or "No"):

	Yes	No
Social Security		
Supplemental Security Income (SSI)		
Veteran's Benefits and or Pensions		
Railroad Retirement		
Other Retirement Benefits or Pensions		
Welfare Checks (AFDC)		
Cash, Gifts, or Contributions from Parents, Relatives, Friends, Others		
Unemployment Checks		
Worker's Compensation		
Payments fro Private Insurance		
Union Benefits (including strike benefits)		
Military Allotments		
Money from Rent of Houses or Apartments		
Money from Roomers or Boarders in Your House		

	Yes	No
Child Support and/or Alimony		
Dividends from Stocks and Bonds		
Interest from Savings Accounts or Certificates of Deposit		
Money from Oil, Gas, or Mineral Leases or Royalties		
Money from Other Private or Public Welfare Agencies		
Money from Farm (including pasture rental, ASC payments, Livestock, or other related money)		
Other Money (include loans made to you and any lump-sum (one time) payments received)		
Educational Loans, Grants, or Scholarships		
List Other Income:		

If you answered "Yes" to any of the questions in item 6 above, complete the following:

Name of Person Receiving Money	Who Provides the Money	If Social Security, Enter Claim No.	Amount Received	How Often Received

7. During the last four months, have your or the household members for whom you want assistance received medical services which have not yet been paid for?..... ☐ Yes ☐ No

8. Do you expect to have any medical expenses during the next six months?..... ☐ Yes ☐ No

9. Are you or anyone in your family now covered by any private health insurance?..... ☐ Yes ☐ No
If "Yes", complete the following items about private health insurance.

Insurance Company Name		Policy No.	Group No.	Name of Policy Holder
Address of Insurance Company			Employment Related? ☐ Yes ☐ No	If "Yes", Employer Name
Beginning Coverage Date	Ending Coverage Date	Names of Persons Covered by This Policy		

10. Have you or anyone who lives with you been covered during the last six months by any health insurance policy under which you are no longer covered?..... ☐ Yes ☐ No

If "Yes", complete the following:

Insurance Company Name		Policy No.	Group No.	Name of Policy Holder
Address of Insurance Company			Employment Related? ☐ Yes ☐ No	If "Yes", Employer Name
Beginning Coverage Date	Ending Coverage Date	Names of Persons Covered by This Policy		

11. List your monthly expenses below:

	AMOUNT	HOW OFTEN BILLED	DATE LAST PAYMENT MADE
Rent or House Payment			
Taxes, Special Assessments			
Home Insurance Payments			
Telephone			
Utilities (gas, electric, etc.)			
Food			
Charge Accounts			
Medical Expenses			
Loans			
Other (specify):			

12. Do you or anyone else in your household pay for someone to care for a child or a disabled or elderly adult so that you can work or get training?..... ☐ Yes ☐ No

Who provides the care?	How often?	How much does it cost?
Address of person who provides the care:		Telephone No.

13. Do you or anyone who lives with you have any of the following (if "Yes", give value):

	Yes	No	Value
A. Savings Account or Credit Union Account			
B. Checking Account			
C. Cash			
D. Stocks, Bonds, etc.			
E. Oil, Mineral Rights			
F. Life Insurance (face value)			
G. Burial Insurance (face value)			
H. Property (real estate)			
I. Livestock			

	Yes	No	Value
J. Cars, Trucks, Motorcycles, Boats and Other Vehicles			

List year, make and model for each vehicle:

Year	Make	Model

14. Do you or anyone who lives with you own or are you buying anything not listed above?..... ☐ Yes ☐ No
If "Yes" list them below (do not list household items such as furniture or appliances or personal items such a jewelry or clothing):

_____

_____

15. Did you or a member of your household sell, trade, or give away anything valuable during the last two years?..... ☐ Yes ☐ No
If "Yes" list them below (do not list household items such as furniture or appliances or personal items such a jewelry or clothing):

_____

_____

16. If some is helping you fill in this form, give his name and address:

Name	Address (Street, City, State, Zip)	Telephone No.

17. Give the name and address of a relative or friend to contact in case of an emergency:

Name	Address (Street, City, State, Zip)	Telephone No.

My answers to all questions and statements I have made are true and correct to the best of my knowledge.

I agree to give eligibility staff at the hospital any information to prove statements about my eligibility for charity care. I will cooperate fully with hospital personnel to get information from any source to prove the statements I made.

I have been told and understand that my failure to meet the obligations set forth may be considered willful withholding of information and can result in the recovery of any loss by repayment, or by filing criminal or civil charges against me.

I certify that I am applying for services under the Methodist Health System Charity Care Policy. I am, or the person responsible for me is, financially unable to pay for all the cost of the necessary services.

I agree to report any changes in the following within 14 days:
Income, Resources, Number of people who live with me, Address, Other circumstances that may affect my eligibility for medical assistance.

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, handicap, or political belief.

BEFORE YOU SIGN BE SURE EACH ANSWER IS COMPLETE AND CORRECT

_____ _____ _____ _____
Signature – Applicant Date Signature – Spouse Date

_____ _____
Signature – Witness Date