	Texas Health Center for Diagnostics and Surgery Plano	PO Box 676290 Dallas, TX 75267-6290
	Texas Health Flower Mound	PO Box 677300 Dallas, TX 75267-7300
	Texas Health Rockwall	PO Box 676882 Dallas, TX 75267-6882
	Texas Health Southlake	PO Box 676281 Dallas, TX 75267-6281
	Texas Institute for Surgery and Texas Health Presbyterian Hospital Dallas	PO Box 676075 Dallas, TX 75267-6075

Date: _____ Guarantor Name: _____

Patient Name: _____ Date of Service: _____

Hospital Account #_____ Medical Record # _____

Attached you will find the Texas Health Resources Joint Venture Charity Care Program Application for the facilities listed above. Please check the facility that this application is for. Completion of this application will enable us to present your account for consideration of financial assistance for your hospital bill(s). This is for your hospital charges only.

We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential information. It will only be shared within Texas Health Partners on a need to know basis.

Please complete each item on the application, in full. If you need additional space for any explanations, please utilize the back of the application, or a separate sheet. Failure to provide a completed application can result in a denial for charity consideration.

Income is reviewed at gross and not net (after deductions). Please provide copies of your current month and two prior months pay stubs and/or proof of any other form of income for the household. If self-employed, please provide a copy of your most recently filed personal income tax return and a current profit and loss statement. Failure to provide the requested documentation can result in a denial for charity consideration.

It is extremely important that you complete this application upon receipt and return it within 15 days from date of this letter.

If you have difficulty completing this application or there is an area that is unclear, please call the facility representative that you are working with if this application is being completed prior to services being rendered or 972-419-1535 or 800-715-7210 to reach Texas Health Partners customer service if services have already been rendered.

Your cooperation is appreciated.

Texas Health Resources℠ Texas Health Partners

APPLICATION FOR CHARITY CARE ASSISTANCE – Page 1

Patient Name: Last _____ First _____MI_____

Social Security #_____ DOB:_____ Hospital Account #:_____

Married _____Single_____ Divorced_____ Widowed_____ Separated_____

Do you have minor children (under 18)?	_____Yes	_____No
Do they live with you?	_____Yes	_____No
Are they your birth/legally adopted children?	_____Yes	_____No
Patient Employed?	_____Yes	_____No
Spouse Employed?	_____Yes	_____No
Do you have medical insurance?	_____Yes	_____No
Are you on disability? How long?	_____Yes	_____No
Are you a veteran?	_____Yes	_____No

FAMILY MEMBERS – (Living in the home)

Spouse: _____

Child:_____Age:_____

Child:_____Age:_____

Child:_____Age:_____

Child:_____Age:_____

** Children over the age of 18 must be full time students and/or counted as a deduction on your tax return**

INCOME (Monthly Amount)	Gross	Net	EXPENSES (Monthly Amount)	
Patient	$ _____	$ _____	Mortgage/Rent	$ _____
Spouse	$ _____	$ _____	Homeowner's Insurance	$ _____
Dependants	$ _____	$ _____	Property Tax	$ _____
Public Assistance	$ _____	$ _____	Utilities	$ _____
Food Stamps	$ _____	$ _____	Food	$ _____
Social Security	$ _____	$ _____	Car Payment	$ _____
Unemployment	$ _____	$ _____	Car Insurance	$ _____
Strike Benefits	$ _____	$ _____	Gasoline	
Worker's Compensation	$ _____	$ _____	Child Care	
Alimony	$ _____	$ _____	Charge Cards (Total per month)	
Child Support	$ _____	$ _____	Loans	
Military Allotments	$ _____	$ _____	Medical Insurance	
Pensions	$ _____	$ _____	Other (please specify)	$ _____
Income from: CD's, Rent, Dividends, Interest	$ _____	$ _____	_____	$ _____
TOTAL	**$ _____**	**$ _____**	**TOTAL**	**$ _____**

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APPLICATION FOR CHARITY CARE ASSISTANCE – Page 2

ASSETS:	Applicant 1/Patient	Applicant 2/Spouse
Checking Account	$	$
Savings Account	$	$
CDs	$	$
IRAs	$	$
Investments(Stocks, Bonds)	$	$
Land/Property	$	$
Other	$	$

VEHICLES:	Make	Estimated Value
Auto # 1		$
Auto #2		$
Motorcycle		$
TOTAL	$	$

EMPLOYMENT INFORMATION:

Name of Applicant's Employer:	Name of Spouse's Employer:
Telephone #:	Telephone #:
Employer's Address:	Employer's Address:
Occupation:	Occupation:

Are you currently applying for Medicaid Benefits? Yes _____ No _____

Have you applied for assistance through your county hospital/indigent program? Yes _____ No _____

Is your Physician donating his/her services? Yes _____ No _____

Is there a potentially liable third-party responsible for your accident/injury/illness? Yes _____ No _____

Is anyone assisting you with payment of your hospital bill(s)? Yes _____ No _____

Who is assisting you? _____

How much assistance are you receiving? $_____

APPLICATION FOR CHARITY CARE ASSISTANCE – Page 3

Please list any other information you feel would be helpful to us in determining your eligibility for assistance in paying your hospital bill: _____

_____

_____

Please list expected earnings and/or funds you will receive during your time off due to your illness (i.e., sick leave, paid time-off, short- and/or long-term disability income, etc.): $_____

Please list expected length of time you will be unable to work and/or earn wages: _____

STATEMENT:

I understand that *(Hospital Name)* may verify the financial information contained in this application and hereby authorize the hospital to contact my employer to certify the information provided and to request reports from credit reporting agencies. I am aware that this information will be used to determine my eligibility for charity assistance, and that the falsification of information in this application may result in denial of charity care assistance. I also understand that any charity approval may be completely, or partially reversed, in the event of a recovery from a third-party, or other source.

I further understand that any charity care I receive shall not be construed as a waiver by hospital of its' lien for reimbursement of its' full, billed charges, and that any reimbursement I receive relating to this hospitalization must be sent to *(Hospital Name)*.

_____ _____

Signature of Requestor (If Patient) Date

_____ _____ _____

Signature of Requestor (If NOT Patient) Relationship Date

Patient's Address: _____ _____

Street Address City, State, Zip

_____ _____

Home Phone Number County of Residence

Required documents in order to process application:

1. **Completed application- Needs to be completed in full**
2. **Last year's tax return- Need to determine income and dependent status**
3. **Most recent paycheck stubs for all applicants- Need last 2-3**