	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 Healht 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 Charity Care Program Application. 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. If you need additional space for any explanations, please utilize the back of the application.

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 you do not receive check stubs, please provide copies of your bank statements showing your monthly deposits. 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 (applicable business office contact numbers).

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:_____

INCOME (Monthly Amount):

	Gross	Net
Patient	$ _____	$ _____
Spouse	$ _____	$ _____
Dependants	$ _____	$ _____
Public Assistance	$ _____	$ _____
Food Stamps	$ _____	$ _____
Social Security	$ _____	$ _____
Unemployment	$ _____	$ _____
Strike Benefits	$ _____	$ _____
Worker's Compensation	$ _____	$ _____
Alimony	$ _____	$ _____
Child Support	$ _____	$ _____
Military Allotments	$ _____	$ _____
Pensions	$ _____	$ _____
Income from: CD's, Rent, Dividends, Interest	$ _____	$ _____
TOTAL	**$ _____**	**$ _____**

Expenses	Monthly Amount
Mortgage/Rent	$ _____
Utilities	$ _____
Car Payments	$ _____
Food/Groceries	$ _____
Credit Cards	$ _____
Other (please specify)	$ _____
_____	$ _____
TOTAL	**$ _____**

ASSETS

Checking Account	$_____
Savings Account	$_____
CD's, IRA's	$_____
Other Investments (Stocks, bonds, etc.)	$_____
Properties, Land other than primary residence	$_____

APPLICATION FOR CHARITY CARE ASSISTANCE – Page 2

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

Are you currently applying for Medicaid Benefits? _____ Yes _____ No
Have you applied for assistance thru your county hospital/indigent program? _____ Yes _____ No
Is your physician donating his/her services? _____ Yes _____ No
Are there any potentially liable third-parties responsible for your accident injury/illness? _____ Yes _____ No
Is anyone assisting you with payment of your hospital bills? _____ Yes _____ No
Who is assisting you? _____
How much assistance are you receiving? _____
List any other information you feel would be helpful to us in determining your eligibility for assistance in paying your hospital bill.

_____
_____
_____

Expected earnings and/or funds you will receive during your time off due to your illness (Sick leave, paid time off, short/long term disability income). $_____

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

I understand that Texas Health Resources may verify the financial information contained in this application in connection with the hospital's evaluation of 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 hospital lien for reimbursement of any amount I owe and that any reimbursement I receive relating to this hospitalization must be sent to Texas Health Resources.

_____ _____
Signature of Person Making Request, If Patient Date

_____ _____
Signature of Person Making Request, If Not Patient Relationship

_____ _____
Patient's Address City State ZIP County Home Telephone Number