FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Texas Health and Human Services Department, Form 3064 and Supplemental Screening Form

Applicants should access all financial assistance forms directly from the hospital website at www.huntsvillememorial.com. Forms should be printed and completed as per the instructions below, and those provided when printing the form from the website.

Huntsville Memorial Hospital utilizes the Texas Health and Human Services Department, Form 3064 for all financial assistance programs.

PERSONAL INFORMATION:

- Print your full legal name.
- Write your home and work telephone number and give a daytime telephone where you can be reached most often.
- Write your current address and which country you presently live in.
- If you are completing this application for someone other than yourself, write the full legal name and social security number of the patient for whom this application is being completed.

HOUSEHOLD MEMBERS AND MONTHLY INCOME:

- Print the names of everyone in your household along with their ages, whether they have income or not.
- Include yourself, other related and unrelated people in your household. (use another piece of paper if you need more space.)
- Write the amount of income each household member received last month, before taxes or anything else is taken out, and where it came from, such as earnings, welfare, child support, social security and other income.
- If any amount last month was more or less than usual, write that person's usual monthly income.

PROOF OF INCOME, RESIDENCY, AND IDENTIFICATION:

- ALL APPLICANTS SHOULD ATTEMPT TO PROVIDE PROOF OF ANY OF THE FOLLOWING TO VERIFY INCOME:

- IRS Form W-2
- Wage and Earnings Statement Paycheck Remittance
- Bank Statement/Records
- Individual Tax Return
- Social Security, Workers Compensation or Unemployment Compensation letter
- Proof of eligibility for Government Program
- Physician disability statement listing term of disability and documentation or proof of three or more months with no income for period of disability
- Telephone verification by employer of patient's income

- Other
- You may also verify your income by: (a) having your employer provide written verification; (2) having your employer speak with a Hospital representative; or (3) providing a written or verbal statement to Hospital representative verifying your gross annual household income.

➢ **If you are unable to provide one of the sources of income documentation listed above, please provide a written explanation in the INCOME VERIFICATION section of the Financial Assistance Application.**

MONTHLY EXPENSES:

➢ Write the usual amount of household expenses.

SIGNATURE AND SOCIAL SECURITY NUMBERS:

➢ All applications should have the signature of an adult household member (unless medical problems or situations, i.e. isolation, I.C.U., etc. are certain.). If it is not possible or feasible to obtain a signature, please explain to hospital staff why signature is unavailable.

➢ The application must have the social security number of the adult who signs.

➢ If the adult does not have a social security number, write "NONE" to show that the adult does not have a social security number.

➢ Additional information may be required to determine your eligibility, depending upon the program for which you are applying.

ELIGIBILITY DETERMINATION:

➢ Eligibility will be determined based on 200% Poverty Income Guidelines.

➢ Approved applications cover charges at Huntsville Memorial Hospital and Rural Health Clinic only.

Sample Form 3064 - English:

County Indigent Health Care Program (CIHCP)

Application for Health Care Assistance

For Office Use Only				
Status ◯ Application ◯ Review	Date Form 3064 Requested/Issued	Date Identifiable Form 3064 Received	Case Record No.	Appointment Date and Time, if applicable

Name (Last, First, Middle)	Home Area Code and Phone No.	Other Area Code and Phone No.

Have you ever used another name? If so, list other names you have used.
◯ Yes ◯ No

Mailing Address (Street or P.O. Box)	Apt. No.	City	State	ZIP Code

Home Address, if different from above. If it is rural, give directions.

1. On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you, whether or not you consider them household members.

Name (Last, First, Middle)	**Social Security No.** (if available)	**Sex** (Male/ Female)	**Date of Birth**	**Relation to You**	**Are you a sponsored alien?**
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No

Note: The word "household" in Questions 2 through 16 refers to you, your spouse and anyone else who lives with you and with whom you have a legal relationship. You do not need to include information on people who live with you but are not part of your "household."

2. What is your household's county and state of residence (where you make your permanent home)?

County: State: Do you plan to remain in this county and state? ◯Yes ◯ No

3. Living Arrangements – Check all boxes that apply to your household.

Own or paying for home
Live in a house provided by someone else
No permanent residence Jail
Live with someone else
Rent house or apartment

4. List your average monthly household expenses.

Expense	Amount
Rent/Mortgage	$
Utilities (gas, water, electric)	$
Phone	$
Transportation (such as gas, car payments, bus)	$
Tax and Insurance on Home Per Year	$
Other:	$
Other:	$
Other:	$

Does anyone pay these household expenses for you? ◯ Yes ◯ No If Yes, who pays? ____________________

5. Are you or is anyone in your household receiving any of the following? ◯ Yes ◯ No

☐ Temporary Assistance for Needy Families (TANF) ☐ Food Stamps ☐ Medicaid Benefits

If Yes, who? ____________________

6. Are you or is anyone in your household pregnant? ◯ Yes ◯ No If Yes, who? ____________________

7. Are you or is anyone in your household disabled? ◯ Yes ◯ No If Yes, who? ____________________

8. Have you or has anyone in your household applied for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)?

◯ Yes ◯ No If Yes, who applied and when? ____________________

9. Do you or does anyone in your household have unpaid health care bills from the last three months? ◯ Yes ◯ No

If Yes, which months? ____________________

10. Do you or does anyone in your household have health care coverage (Medicare, health insurance, Veterans Affairs, Tricare, etc.)?

◯ Yes ◯ No If Yes, who? ____________________

11. How much money do you have in your wallet, in your home, in bank accounts or other locations? ☐

12. How many cars, trucks or other vehicles do you and anyone in your household have? List the year, make and model below. ☐

Year	**Make and Model**	+
1		−

13. Do you or does anyone in your household own or pay for a home, lot, land or other things? ◯ Yes ◯ No

14. Did you or did anyone in your household sell, trade, or give away any cash or property during the last three months? ◯ Yes ◯ No

15. Have you or has anyone in your household worked in the last three months? ◯ Yes ◯ No If Yes, who? ____________________

16. List all of your household's income below. Include the following: government checks; money from training or work; money you collect from charging room and board; cash gifts, loans or contributions from parents, relatives, friends and others; sponsor's income; school grants or loans; child support; and unemployment.

Name of Person Receiving Money	Name of Agency, Person or Employer Providing Money	Amount Received	How Often Received?

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff and the county any information necessary to prove statements about my eligibility. I agree to report any of the following changes within 14 days:

- Income
- Resources
- Number of people who live with me
- Address
- Application for or receipt of SSI, TANF or Medicaid

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability or political belief; that I may request a review of the decision made on my application or recertification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

I understand that by signing this application, I am giving the county the right to recover the cost of health care services provided by the county from any third party.

I agree to give the county any information it needs to identify and locate all other sources of payment for health care services.

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

Before you sign, be sure each answer is complete and correct. If the applicant is married and the spouse is a household member, the spouse may also sign and date this form, even if the spouse is a disqualified household member.

Signature — Applicant

Date

Signature — Spouse

Date

Signature — Person Helping Complete Form 3604

Signature — Applicant's Representative

Signature — Witness (if applicant signed with "X")

Address of Person Helping Complete Form 3064 (Street, City, State, ZIP Code):

Area Code and Phone No.:

Sample Form 3064 - Spanish:

Programa del Condado de Atención Médica para Indigentes

Solicitud de asistencia médica

For Office Use Only (Solo para uso de la oficina)				
Status ◯ Application ◯ Review	Date Form 3064 Requested/Issued	Date Identifiable Form 3064 Received	Case Record No.	Appointment Date and Time, if applicable

Nombre (apellido, primer nombre, segundo nombre)	Código postal y núm. de teléfono.	Otro núm. de teléfono con código de área

¿Alguna vez ha usado otro nombre? De ser así, indique los nombres que ha usado.
◯ Sí ◯ No

Domicilio postal (calle o apartado postal)	Núm. de apto.	Ciudad	Estado	Código postal

Dirección postal, si es diferente a la anterior. Si es un domicilio rural, indique cómo llegar.

1. En la tabla a continuación, use el primer renglón para poner información sobre usted. En los otros renglones, ponga la información de todas las personas que viven en la casa con usted, aún si no se consideran miembros del hogar.

Nombre (Apellido, nombre, segundo nombre)	**Núm. de Seguro Social** (si lo sabe)	**Sexo** (Masculino/ Femenino)	**Fecha de nacimiento**	**Relación con usted**	**¿Es usted extranjero patrocinado?**
					◯ Sí No
					◯ Sí No
					◯ Sí No
					◯ Sí No
					◯ Sí No
					◯ Sí No
					◯ Sí No

Nota: La palabra "hogar" en las preguntas 2 a 16 se refiere a usted, su cónyuge y cualquier otra persona que viva con usted y con la que tenga una relación legal. No es necesario incluir información sobre las personas que viven con usted pero que no forman parte de su "hogar".

2. ¿En qué condado y estado está ubicado su hogar (dónde está su hogar permanente)?

Condado: Estado: ¿Piensa permanecer en este condado y estado? ◯ Sí ◯ No

3. Plan de vivienda: Seleccione todas las casillas que correspondan a su hogar.

Es dueño o está pagando por el hogar
Vive en una casa que otra persona paga
No tiene residencia permanente
Vive con otra persona
Renta una casa o apartamento
Cárcel

4. Anote los gastos promedios mensuales de su hogar.

Renta/hipoteca	$
Servicios públicos (gas, agua, luz)	$
Teléfono	$
Servicios de transporte (como gasolina, pagos del carro, autobús)	$
Impuestos y seguro anuales del hogar	$
Otro gasto:	$
Otro gasto:	$
Otro gasto:	$

¿Paga alguien estos gastos del hogar por usted? ◯ Sí ◯ No Si contesta que sí, ¿quién? ______

5. ¿Recibe usted o alguien de su hogar alguno de los siguientes beneficios? ◯ Sí ◯ No

☐ Asistencia Temporal a Familias Necesitadas (TANF) ☐ Programa SNAP (estampillas para alimentos) ☐ Beneficios de Medicaid

Si contesta que sí, ¿quién recibe estos beneficios? ______

6. ¿Está usted o alguien de su hogar embarazada? ◯ Sí ◯ No Si contesta que sí, ¿quién está embarazada? ______

7. ¿Tiene usted o alguien de su hogar una discapacidad? ◯ Sí ◯ No Si contesta que sí, ¿quién tiene una discapacidad? ______

8. ¿Ha solicitado usted o alguien de su hogar Seguridad de Ingreso Suplementario (SSI) o Seguro de Incapacidad del Seguro Social (SSDI)?

◯ Sí ◯ No Si contesta que sí, ¿quién solicitó estos beneficios y cuándo? ______

9. ¿Tiene usted o alguien en su hogar facturas sin pagar por servicios de atención médica de los últimos tres meses? ◯ Sí ◯ No

Si contestó que sí, ¿de cuáles meses? ______

10. ¿Tiene usted u otra persona en su hogar cobertura de atención médica (Medicare, seguro médico, Asuntos de Veteranos, Tricare, etc.)?

◯ Sí ◯ No Si contesta que sí, ¿quién tiene cobertura? ______

11. ¿Cuánto dinero tiene en su cartera, en su casa, en cuentas bancarias o en otros lugares? ______

12. ¿Cuántos carros, camiones u otros vehículos tienen usted y los demás miembros de su hogar? A continuación, anote el año, marca y modelo.

Año	Marca y modelo	+
1		−

13. ¿Es dueño o paga usted o alguien de su hogar una casa, un lote, unas tierras u otra propiedad? ◯ Sí ◯ No

14. En los últimos tres meses, ¿vendió, intercambió o regaló usted u otro miembro del hogar algún dinero o propiedad? ◯ Sí ◯ No

15. ¿Ha trabajado usted o alguien de su hogar en los últimos tres meses? ◯ Sí ◯ No Si contesta que sí, ¿quién trabajó? ______

16. En la siguiente tabla anote todos los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero de una capacitación o trabajo; dinero que cobra por dar alojamiento y comida; dinero regalado, préstamos o contribuciones de los padres, familiares, amigos y otras personas; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención infantil, y pagos por desempleo.

Nombre de la persona que recibe el dinero	Nombre del departamento, persona o empleador que aporta el dinero	Cantidad recibida	Frecuencia del ingreso

Las declaraciones que he hecho, incluidas las respuestas que he dado, son verdaderas y correctas a mi leal saber y entender. Estoy de acuerdo en darle al personal que determina el derecho a la participación y al condado cualquier información que sea necesaria para comprobar las declaraciones respecto a mi derecho a la participación. Estoy de acuerdo en informar de cualquier de los siguientes cambios en un plazo de 14 días:

- Ingresos
- Recursos
- Número de personas que viven conmigo
- Dirección
- Solicitud o participación en SSI, TANF o Medicaid

Me han informado y tengo por entendido que esta solicitud se tramitará sin distinción de raza, color, religión, credo, origen nacional, edad, sexo, discapacidad o creencia política; que puedo pedir una revisión de la decisión que se tome sobre mi solicitud o la recertificación de asistencia, y que puedo pedir oralmente o por escrito una audiencia imparcial con respecto a cualquier acción que afecte la concesión o la terminación de asistencia.

Tengo entendido que, al firmar esta solicitud, le doy al condado el derecho de recuperar el costo de los servicios de atención médica proporcionados por el condado de cualquier tercero.

Estoy de acuerdo en dar al condado cualquier información que necesite para identificar y localizar todas las otras fuentes de pago de los servicios de salud.

Se me ha informado y entiendo que no cumplir con las obligaciones establecidas podría considerarse una retención intencional de información de mi parte y podría dar lugar a que se recuperen los fondos mediante el reembolso o la presentación de cargos civiles o penales en mi contra.

Antes de firmar, asegúrese de haber dado respuestas completas y correctas. Si el solicitante está casado y su cónyuge es un miembro del hogar, el cónyuge también puede firmar y fechar este formulario aunque sea un miembro del hogar excluido.

Firma del solicitante | Fecha | Firma del cónyuge | Fecha

Firma de la persona que ayudó a llenar el Formulario 3604 | Firma del representante del solicitante | Firma del testigo (si el solicitante firmó con una "X")

Dirección de la persona que ayudó a llenar el Formulario 3604 (calle, ciudad, estado, código postal): | Código de área y tel.:

Sample Supplemental Information Form:

RESOURCE CORPORATION OF AMERICA

Does patient have primary insurance? ☐ N ☐ Y ______ Room # ______

Account Number: ______ SS# ______

Patient Email Address: ______ DOB: ______

Patient Demographic

☐ Same as Demo

Last, First: ______
Maiden Name: ______
Street: ______
City, State: ______
County & Zip: ______
Mailing Address (if different from above) ______
Phone: ______
Cell: ______

Citizenship Status

☐ US
☐ Legal Resident Entry Mo/Yr ______
☐ Work Permit
☐ VISA (Student/Tourist/Business)
☐ Foreign Citizen (72 hour Pass)
☐ Undocumented
☐ Refugee/Asylee From ______
Place of Birth: ______
Patient Primary Language: ______
Mother's Maiden Name: ______
Father's Name: ______
Difficulty Reading/writing? ☐ Y ☐ N

Guarantor

☐ Same as Patient

Guarantor: ______
DOB: ______
SS#: ______
Street: ______
City, State: ______
County & Zip: ______
Phone: ______
Cell: ______

If PO Box need physical

Household Composition

Patient's Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated (how long) ______

Spouse Information

Spouse Name: ______ DOB: ______
SS#: ______ ☐ US Citizen ☐ Legal Resident ☐ Undocumented

Tax Calculations

Did applicant file taxes in prior year? ☐ Y ☐ N Will they file? ☐ Y ☐ N
Under what status? ☐ Single ☐ Married/ Jointly ☐ Married/ Separate
Adj Gross Income ______ # Dependents Claimed? ______
Were you claimed as a tax dependent by someone? ☐ Y ☐ N
Relationship to Tax Filer who claimed you? ______

Child 1: ☐ Dir Related ☐ Step Child ☐ Dependent Claimed	Child 2: ☐ Dir Related ☐ Step Child ☐ Dependent Claimed	Child 3: ☐ Dir Related ☐ Step Child ☐ Dependent Claimed	Child 4: ☐ Dir Related ☐ Step Child ☐ Dependent Claimed
Name: ______	Name: ______	Name: ______	Name: ______
DOB: ______	DOB: ______	DOB: ______	DOB: ______
SS# ______	SS# ______	SS# ______	SS# ______
US Citizen: ☐ Yes ☐ No	US Citizen: ☐ Yes ☐ No	US Citizen: ☐ Yes ☐ No	US Citizen: ☐ Yes ☐ No
Sex: ☐ M ☐ F	Sex: ☐ M ☐ F	Sex: ☐ M ☐ F	Sex: ☐ M ☐ F
Coverage? ☐ MCD ☐ Ins ☐ None	Coverage? ☐ MCD ☐ Ins ☐ None	Coverage? ☐ MCD ☐ Ins ☐ None	Coverage? ☐ MCD ☐ Ins ☐ None

Patient Income

☐ Employed ☐ Self-Employed ☐ Cash/Day Work ☐ Unemployed (Since ______) Employer: ______

☐ Hourly $______ Hrs/PP: ______ ☐ Salary Rate $______ Employer Phone: ______

Frequency Paid: ☐ Weekly (x 4.33) ☐ Bi-Weekly (x 2.17) ☐ Semi-Monthly (x 2.00) ☐ Monthly Length of Employment: ______ ☐ Mo ☐ Yrs

Est. Mo. Income $ ______ Last check received $ ______ Income DOS Month $ ______

Spouse Income

☐ Employed ☐ Self-Employed ☐ Cash/Day Work ☐ Unemployed (Since ______) Employer: ______

☐ Hourly $______ Hrs/PP: ______ ☐ Salary Rate $______ Employer Phone: ______

Frequency Paid: ☐ Weekly (x 4.33) ☐ Bi-Weekly (x 2.17) ☐ Semi-Monthly (x 2.00) ☐ Monthly Length of Employment: ______ ☐ Mo ☐ Yrs

Est. Mo. Income $ ______ Last check received $ ______ Income DOS Month $ ______

Does patient or spouse have insurance available thru employer but declined coverage due to cost? ☐ Y ☐ N If yes, what was monthly premium? ______

Has patient or spouse lost health coverage from an employer in the last 60 days? ☐ Y ☐ N SEP Eligible? ☐ Y ☐ N COBRA Eligible? ☐ Y ☐ N Cost for COBRA? ______

Other Income

Count (for MAGI Programs)

☐ Unemployment $______ ☐ Widow's/Survivor's Benefits $______
☐ SSD $ ______ How Long Until MCR ______ ☐ Other $ ______
☐ Retirement / Pension $ ______ ☐ Cash Assistance $______
Cash Assistance Received from: ______

Do Not Count (for MAGI Programs)

☐ Child Support $ ______ ☐ Court-Ordered ☐ Voluntary
☐ SSI $ ______ MCD Benefits ☐ Y ☐ N ☐ Food Stamps $ ______
☐ VA Benefits $ ______ ☐ Workers Comp $ ______ ☐ GI Bill $ ______

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Patient Resources
(Do Not Count for MAGI Programs)

Checking $ Institution: ______ Savings $ Institution: ______

Auto 1
☐ Own ☐ Financed Pymt $______ ☐ Leased
Yr: ____ Make: ______ Model: ______

Auto 2
☐ Own ☐ Financed Pymt $______ ☐ Leased
Yr: ____ Make: ______ Model: ______

Auto 3
☐ Own ☐ Financed Pymt $______ ☐ Leased
Yr: ____ Make: ______ Model: ______

Any Additional Assets: ☐ Stocks $ ______ ☐ Bonds $ ______ ☐ Retirement / 401(k) $ ______ ☐ IRA $ ______
☐ Burial Plot $ ______ ☐ Life Ins $ ______ ☐ Real Property $ ______ ☐ Boat / RV / ATV $ ______ ☐ Other ______

Patient Expenses

Home: ☐ Own ☐ Rent Mortgage / Lease Amt $ ______
☐ Staying with ______
Food: Avg. Mo. Exp. $ ______
Gas: Avg. Mo. Exp. $ ______
Medications: Avg. Mo. Exp. $ ______
Electricity: Avg. Mo. Exp. $ ______
Water: Avg. Mo. Exp. $ ______

Phone
☐ Home $ ______
☐ Cell $ ______

Patient Deductions

☐ Alimony Paid $ ______
☐ Student Loan Interest $ ______
☐ Educator Expenses $ ______
☐ Health Savings Account (HSA) $ ______
☐ IRA Deductions $ ______
☐ Self-Employment Business Exp $ ______

Young Adult

Is Patient under age of 26? ☐ Y ☐ N
Does patient have a parent with employer sponsored health insurance? ☐ Y ☐ N
Date of parent's open enrollment period? ______
Is patient a former foster care child and now between the ages of 18 and 26? ☐ Y ☐ N

Hospitalization

Admitting Diagnosis: ______ Treating Diagnosis: ______

If diagnosis is Breast or Cervical Cancer, is this initial diagnosis/treatment? ☐ Y ☐ N Other Medical Conditions: ______

Is Patient Pregnant ☐ Y ☐ N
Due Date: ______

Related to Work? ☐ Y ☐ N

Related to Accident ☐ Y ☐ N (If Y was pt at Fault) ☐ Y ☐ N Date of Accident: ______ ☐ MVA ☐ TPL
Ins. Name: ______ Ins. Phone: ______ Claim # ______ Policy # ______
At Fault Party Information
Ins. Name: ______ Ins. Phone: ______ Claim # ______ Policy # ______

Related to a crime ☐ Y ☐ N Police report filed ☐ Y ☐ N Agency Reported to: ______ Report/Incident # ______
Date of Incident ______ Brief Description of Crime ______

Applied for disability ☐ Y ☐ N ☐ RSDI ☐ SSI
Stage: ☐ Initial ☐ Recon ☐ Hearing Original File Date: ______ Alleged onset date: ______
Disability Attorney/Rep: ☐ Y ☐ N Name of Representative: ______ Phone: ______
Does patient claim to be disabled? ☐ Y ☐ N Is patient able to work? ☐ Y ☐ N Usual Occupation? ______ Yrs of Exp? ______
Does patient plan on returning to work? ☐ Y ☐ N Highest Level of Education Completed: ☐ Elementary ☐ Middle School ☐ High School ☐ GED ☐ Tech Cert. Degree ☐ College/Grad

Patient must answer yes to all four questions in order to qualify for 1,011 Bill Reimbursement

Is the patient a veteran? ☐ N ☐ Y
Is the patient reg. in the VA Health Care System? ☐ N ☐ Y
Has patient recvd services through the VA in last 24 mo's? ☐ N ☐ Y
Did patient receive Emergency Service at your facility? ☐ N ☐ Y

Have you applied for MCD before? ☐ Y ☐ N If yes, when? ______
Case Worker Name: ______
Does anyone in your household, including yourself, smoke tobacco? How many? ☐ Y ☐ N
# of people______?

Regional Questions

Are you on CHIP Perinatal? ☐ N ☐ Y CHIP ID # ______ ☐ Below 185% ☐ Above 185%
Are you currently on a county program? ☐ N ☐ Y Name of County Program: ______
Example: Gold Card/MAP/Solor County

Patient Signature: ______ Date: ______ Witness: ______ Date: ______