Hospital Financial Assistance Application

		Account #		
Patient Name	Date of Birth	Phone #	Marital Status	Patient's Social Security #
Guarantor Name	Date of Birth	Relation to Patient	Guarantor's Social Security #	
Spouse Name	Date of Birth	Phone #	Spouse's Social Security #	
Guarantor Address PHYSICAL ADDRESS		Other Phone #		
City, State, Zip				
Guarantor Employer (name, address, phone #)		Spouse Employer (name, address, phone #)		

Occupation:	Length:	Occupation:	Length:
Guarantor's Gross Income	$	Spouse Gross Income	$
Wages	$ -	Wages	$ -
Disability / SSI	$ -	Disability / SSI	$ -
Rental Income	$ -	Rental Income	$ -
Alimony/Child Support	$ -	Alimony/Child Support	$ -
Gov't Assistance	$ -	Gov't Assistance	$ -
Unemployment	$ -	Unemployment	$ -
Worker's Comp	$ -	Worker's Comp	$ -
Interest / Dividends	$ -	Interest / Dividends	$ -
Military	$ -	Military	$ -
Inheritance	$ -	Inheritance	$ -
Any Possible Settlement	$ -	Any Possible Settlement	$ -
Other Income (i.e. mo.	$ -	Other Income (i.e. mo.	$ -
monetary support from	$ -	monetary support from	$ -
family/friends/relative)	$ -	family/friends/relative)	$ -
Total Monthly Income	$ -	**Total Monthly Income**	$ -

Total Monthly Income Combined $ -

Gross Income (IRS worksheet 1040; 1040A; ect…) $ -

List the number of household members and those who contribute to income: Include the number of dependents for whom you provide more than one-half support (eligible dependents as defined by the IRS guidelines.)

Name	Relationship

Name	Relationship

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I understand that this application is made in order that Uvalde Memorial Hospital and/or Uvalde Medical and Surgical Assoc. can judge my eligibility for uncompensated services. If any information I have given proves to be untrue or is withheld, I understand that the hospital may re-evaluate my financial status and take whatever action is deemed to be appropriate to include denying this application in its entirety now and any future applications.

I/We certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc) which my be available for payment of my hospital charges, and I/we will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

Guarantor Signature	Date	Spouse Signature	Date

STATE OF TEXAS
COUNTY OF UVALDE

I, the undersigned, state, under oath and under penalty for perjury, that I have personal knowledge of the facts stated in the attached application and they are true and correct.

_____
Signature

SUBSCRIBED AND SWORN TO before me, the undersigned Notary Public, on this the _____ day of _____, 20____ .

_____
Notary Public In and For The State of Texas

My Commission Expires

_____

ATTACHMENT
REVISED: AUGUST 25,2011