FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Texas Health and Human Services Department, Form 100

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 100 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 100:

TEXAS Health and Human Services

FOR OFFICE USE ONLY / PARA USO DE LA OFICINA				
Status ☐ Application ☐ Review	Date Form 100 is Requested/Issued	Date Identifiable Form100 is Received	Case Record Number	Appointment Date and Time, if applicable

APPLICATION FOR HEALTH CARE ASSISTANCE / SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

Name (Last, First, Middle)/Nombre (Apellido, primer, segundo)	Home Telephone No./Teléfono de la casa	Other Telephone No./Otro número de teléfono

Have you ever used another name? If so, list other names you have used./¿Ha usado alguna vez otro nombre? Sí es el caso, enumere los nombres que ha usado.

☐Yes/Sí ☐No

Mailing Address (Street or P.O. Box)/Dirección Postal (Calle o Apdo.)	Apt.# /Apto.#	City/Ciudad	State/Estado	ZIP

Home Address, if different from above. If it is rural, give directions. / Domicilio particular, si es diferente a la dirección de arriba. Si es rural, explique cómo llegar.

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.** / En la tabla a continuación, llene la primera línea con información acerca de usted mismo. Llene las líneas restantes acerca de todos que viven en la casa con usted, los considere miembros de la unidad familiar o no.

Name (Last, First, Middle) Nombre (Apellido, primero, segundo)	Social Security Number (if available) Número de Seguro Social (si lo tiene a su disposición)	Sex Sexo Male/Female Hombre/Mujer	Date of Birth Fecha de nacimiento	What Relation to you? ¿Parentesco con usted?	Are you a sponsored alien? ¿Es usted un extranjero patrocinado?
				MYSELF Yo mismo	

The word "household" in Questions #2 - #16 refers to: you, your spouse, and anyone else that 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."
Las palabras "unidad familiar" en las preguntas #2- #16 se refiere a: usted, su esposo o esposa, y cualquier otra persona que vive con usted y con quien tiene una relación legal. No necesita incluir información de las personas quienes viven con usted que no son parte de su "unidad familiar."

2. **What is your household's county and state of residence (where you make your permanent home)?**
¿En qué condado y en qué estado viven (tienen su hogar permanente) usted y las personas de la unidad familiar?

County/Condado _____ State/Estado _____

Do you plan to remain in this county and state?
¿Piensa quedarse en este condado y este estado?..... ☐Yes/Sí ☐No

3. **Living Arrangements**/Vivienda
Check all boxes that apply to your household./Marque todas las cajitas que se apliquen a su caso.

☐ **Own or paying for home** Soy dueño de mi casa o la estoy comprando
☐ **Live in a house provided by someone else** Vivo en una casa ajena
☐ **No permanent residence** No tengo residencia permanente
☐ **Live with someone else** Vivo con otra persona
☐ **Rent House/Apartment** Rento una casa o apartamento
☐ **Jail** Cárcel

4. **List your average monthly household expenses.**/Enumere los gastos mensuales de la unidad familiar.

Rent/Mortgage/Renta/hipoteca ..... $ _____

Utilities (gas, water, electric)/Servicios públicos (gas, agua, luz) ..... $ _____

Telephone/Teléfono ..... $ _____

Transportation, such as gas, car payments, bus/Transportación, tal como gasolina, pagos del carro, autobús ..... $ _____

Tax and Insurance on home per year/Impuesto y seguro anual de la casa ..... $ _____

Other/Otro ..... $ _____

Other/Otro ..... $ _____

Other/Otro ..... $ _____

Does anyone pay these household expenses for you?
¿Hay otra persona que paga estos gastos de la unidad familiar por usted? ..... ☐Yes/Sí ☐No

If Yes, who?/Si contesta "Sí," ¿ quién? _____

5. **Are you – or is anyone in your household – receiving ☐ TANF ☐ Food Stamp ☐ Medicaid benefits?**
¿Está usted o alguien de la unidad familiar recibiendo beneficios de TANF, estampillas para comida, y/o Medicaid? ..... ☐Yes/Sí ☐No

If Yes, who?/Si contesta "Sí," ¿ quién? _____

6. **Are you – or is anyone in your household – pregnant?**
¿Está usted o alguien de la unidad familiar embarazada? ..... ☐Yes/Sí ☐No **If Yes, who?**
Si contesta "Sí," ¿ quién? _____

7. **Are you – or is anyone in your household – disabled?**
¿Está usted o alguien de la unidad familiar incapacitada? ..... ☐Yes/Sí ☐No **If Yes, who?**
Si contesta "Sí," ¿ quién? _____

8. **Have you – or has anyone in your household – applied for SSI or SSDI?**
¿Alguna vez usted o alguien de la unidad familiar solicitó beneficios de SSI o SSDI? ..... ☐Yes/Sí ☐No

If Yes, who applied and when?
Si contesta "Sí," quién los solicitó y cuando? _____

9. **Do you – or does anyone in your household – have unpaid health care bills from the last three months?**
¿Tiene usted o alguien de la unidad familiar cuentas médicas sin pagar de los últimos tres meses? ..... ☐Yes/Sí ☐No

If Yes, which months?
Si contesta "Sí," ¿Cuáles meses? _____

10. **Do you – or does anyone in your household – have health care coverage (Medicare, health insurance, V. A., Tricare, etc.)?**
¿Tiene usted o alguien de la unidad familiar la cobertura médica (Medicare, seguro médico, V. A., Tricare, etc.)? ..... ☐Yes/Sí ☐No

If Yes, who?/Si contesta "Sí," ¿ quién? _____

11. **How much money do you have? For example, on your person, in your home, in bank accounts, or other locations?**
¿Cuánto dinero tiene usted; por ejemplo, en el bolsillo, en la casa, en las cuentas bancarias, o en otros lugares? ..... $

12. **How many cars, trucks, or other vehicles do you – and anyone in your household -- have? List the year, make, and model in the chart below.**/¿Cuántos carros, camionetas u otros vehículos tienen usted y las personas de la unidad familiar? Anote el año, la marca, y el modelo en la tabla a continuación. .....

	Year/Año	Make and Model/Marca y Modelo
1.		
2.		

	Year/Año	Make and Model/Marca y Modelo
3.		
4.		

13. **Do you – or does anyone in your household – own or pay for a home, lot, land, or other things?**
¿Tiene o paga usted o alguien de la unidad familiar una casa, un lote, un terreno, u otros bienes? ..... ☐Yes/Sí ☐No

14. **Did you – or did anyone in your household – sell, trade, or give away any cash or property during the last three months?**
Durante los últimos tres meses, ¿traspasó, vendió o regaló usted o alguien de la unidad familiar dinero o alguna propiedad? ..... ☐Yes/Sí ☐No

15. **Have you – or has anyone in your household – worked in the last three months?**
¿Ha trabajado usted o alguien de la unidad familiar en los últimos tres meses? ..... ☐Yes/Sí ☐No **If Yes, who?**
Si contesta "Si," ¿quien? _____

16. **List all of your household's income below. Be sure to 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.**/Haga una lista de los ingresos de la unidad familiar a continuación. Asegúrese de anotar: Cheques del gobierno; ingresos de trabajo o de capacitación; dinero que recibe de cobros de cuarto y comida; regalos en efectivo, préstamos, o aportaciones de sus padres, familiares, amigos, y otras personas; los ingresos del patrocinador; becas o préstamos de la escuela; o pagos por desempleo.

Name of person receiving money Nombre de la persona que recibe el dinero	Name of agency, person, or employer who provides the money Nombre del patrón, la persona o la agencia que paga el dinero	Amount received Cantidad recibida	How often received? (daily, weekly, every two weeks, twice a month, monthly?) ¿Con qué frecuencia lo recibe? (¿diariamente, por semana, cada quincena, dos veces al mes, una vez al mes?)

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 re-certification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

A mi leal saber y entender, las declaraciones que he hecho, y mis respuestas a todas las preguntas, son verdaderas y correctas.

Me comprometo a dar al personal que verifica la elegibilidad y al condado toda la información necesaria para comprobar mis declaraciones sobre la elegibilidad.

Me comprometo a avisar, dentro de los 14 días, de cualquier cambio de:

- Ingresos
- Recursos
- Número de personas que viven conmigo
- Dirección
- Solicitud de SSI, TANF, o Medicaid o la entrega de cualquiera de estas.

Me han dicho y comprendo que esta solicitud será considerada sin discriminación por raza, color, religión, credo, origen nacional, edad, sexo, discapacidad, ni afiliación política; que puedo pedir una revisión de la decisión que se haga acerca de mi solicitud de asistencia o recertificación para asistencia; y que puedo pedir, oralmente o por escrito, una audiencia imparcial sobre cualquier acción que afecte la entrega o la terminación de asistencia de atención médica.

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.

Comprendo que al firmar esta solicitud, doy al condado el derecho a recuperar de cualquier tercero el costo de los servicios médicos proporcionados por el condado. Me comprometo a dar al condado la información necesaria para identificar y localizar cualquier otro fuente de pagos por mis servicios médicos.

Me han dicho y comprendo que si dejo de cumplir con las obligaciones especificadas en ésta podría considerarse como una retención intencional de información y podría dar lugar a la recuperación de pérdidas por medio de la devolución de pagos o por medio de la presentación de cargos criminales en mi contra.

BEFORE YOU SIGN, BE SURE EACH ANSWER IS COMPLETE AND CORRECT.
ANTES DE FIRMAR, ASEGÚRESE DE QUE CADA RESPUESTA SEA COMPLETA Y CORRECTA.

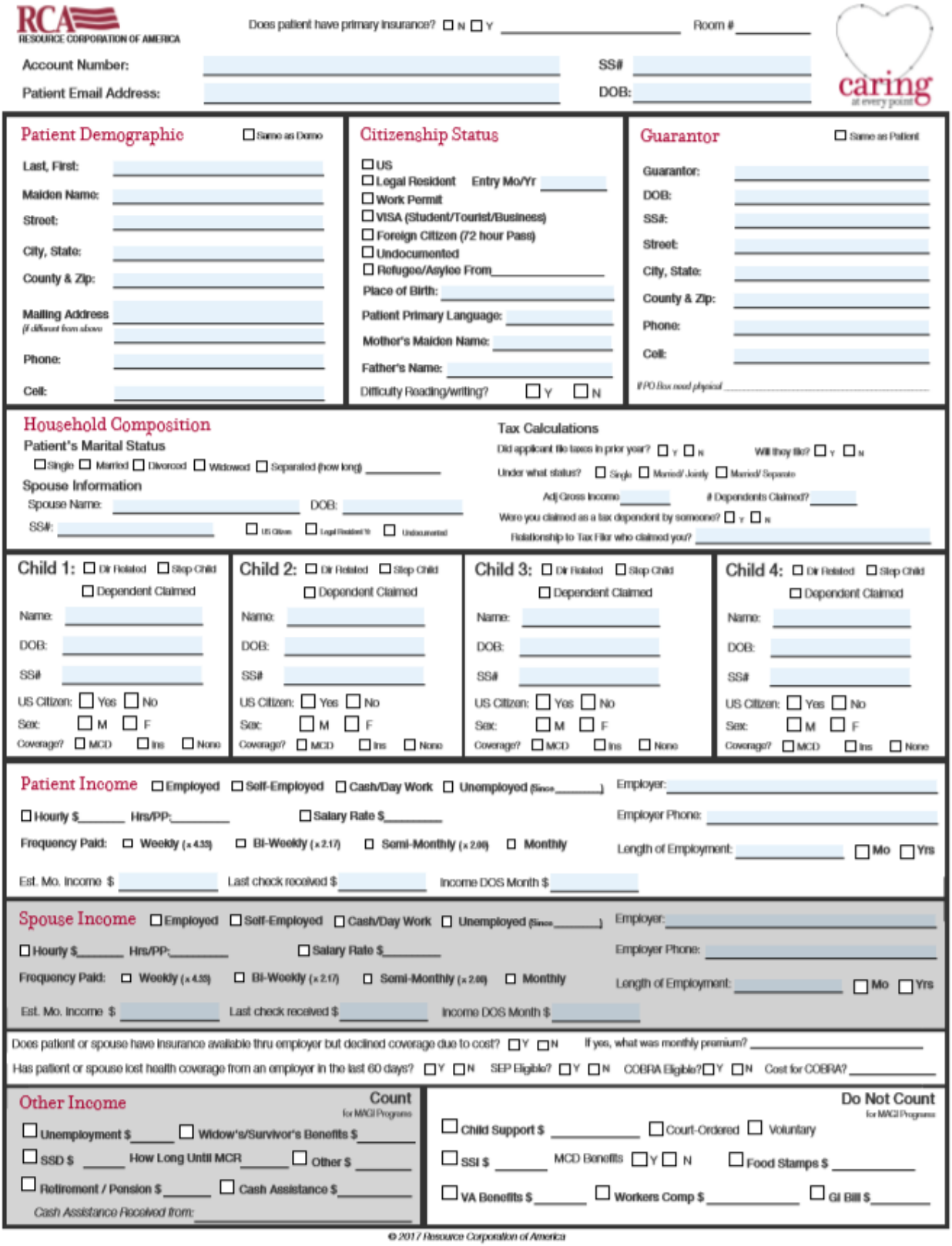
Signature – Applicant / Firma – Solicitante	**Date** / Fecha	**Signature – Spouse** / Firma – Esposo o Esposa	**Date** / Fecha

If the applicant is married and his/her spouse is a household member, the spouse may also sign and date this Form 100 even if the spouse is a disqualified household member. Si el/la solicitante está casado/a y su esposo o esposa vive en la misma casa, el cónyuge también puede firmar que su esposo o esposa también firme esta Forma 100, aunque no tenga derecho de recibir asistencia.

Signature - Person Who Helped Complete This Application / Date Firma - Persona que ayudó a llenar esta solicitud / Fecha	**Signature - Applicant's Representative / Date** Firma – Representante del solicitante / Fecha	**Signature – Witness (If signed with "X") / Date** Firma – Testigo (si firma con "X") / Fecha

Address (Street, City, State, ZIP) and telephone number of anyone who helped complete this Form 100/Dirección (Calle, Ciudad, Estado, ZIP) y teléfono de la persona que ayudó a llenar esta Forma 100

Sample Supplemental Information Form:



RCA
RESOURCE CORPORATION OF AMERICA

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

Account Number: _____ SS# _____

Patient Email Address: _____ DOB: _____

caring at every point

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 Y# ☐ 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

Name: _____

DOB: _____

SS# _____

US Citizen: ☐ Yes ☐ No

Sex: ☐ M ☐ F

Coverage? ☐ MCD ☐ Ins ☐ None

Child 2: ☐ Dir Related ☐ Step Child ☐ Dependent Claimed

Name: _____

DOB: _____

SS# _____

US Citizen: ☐ Yes ☐ No

Sex: ☐ M ☐ F

Coverage? ☐ MCD ☐ Ins ☐ None

Child 3: ☐ Dir Related ☐ Step Child ☐ Dependent Claimed

Name: _____

DOB: _____

SS# _____

US Citizen: ☐ Yes ☐ No

Sex: ☐ M ☐ F

Coverage? ☐ MCD ☐ Ins ☐ None

Child 4: ☐ Dir Related ☐ Step Child ☐ Dependent Claimed

Name: _____

DOB: _____

SS# _____

US Citizen: ☐ Yes ☐ No

Sex: ☐ M ☐ F

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 $_____

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 MM 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/MAVY color County

Patient Signature: _____ Date: _____ Witness: _____ Date: _____