YOAKUM COUNTY HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

Patient Name		Account Number			
Guarantor Name		Birthdate		Age	
Address		Telephone			
Marital Status	Single	Married	Divorced	Widowed	Separated
Patient Social Security Number		Spouse Social Security Number			

County in which you reside in:

I am responsible for the support of the following:

Name	Birthdate	Relationship

Health Insurance / Medicare / Medicaid Information: (Circle One)

Group / Subscriber Number		Policy Owner	

Income: (Monthly)

Social Security	$	Unemployment Compensation	$
Veterans Pension	$	Workers Compensation	$
Railroad Retirement	$	Union Benefits	$
Employment	$	Child Support / Alimony	$
Dividends / Interest	$	Public Assistance, Food Stamps, Aid for Dependent Children	$
Rental Income	$	Other (Specify)	$
Retirement Income	$		$

Employment:

Name of Person Employed	Employer	Gross Pay		
		$	Weekly	Monthly
		$	Weekly	Monthly
		$	Weekly	Monthly

Deductions from Pay:

Federal / State Tax	Social Security	Union	Insurance	Pension	Other
$	$	$	$	$	$
$	$	$	$	$	$
$	$	$	$	$	$

I / We Own the Following:

Cash on Hand / Money in the Bank (Specify Bank)	$
Stocks / Bonds / Securities (Cash Value)	$
Real Estate	$
Other Real Estate (Location)	$

Monthly Expenses:

Automobiles	Car A	Car B	Car C
Year			
Make			
Model			
Balance Owed	$	$	$

Rent / Mortgage	$	Utilities	$	Transportation	$
Real Estate Tax	$	Food	$	Other (Specify)	$

Insurance (Specify Company)	$	Weekly	Monthly

Medical (Specify Hospital or Doctors Name)	$	Weekly	Monthly
Total Medical Bills Owed	$		

Installment Notes (Specify Creditor)	$	Weekly	Monthly

Other Debts (Specify Person or Entity Owed)	$

Comments:

I represent that the above information is true and correct to the best of my knowledge.

Signature: **Date:**

EXHIBIT A
YOAKUM COUNTY HEALTH SYSTEM

CHARITY CARE
QUESTIONNAIRE

Applicant's Name Relationship to Patient

Name of Patient DOB Marital Status

Address Phone#

Previous Address

Spouse's Name Spouse's DOB

Your Social Security Number

Spouse's Social Security Number

Yes No

Do you have medical insurance:

Have you applied for Indigent Care with the County?

Were you denied Indigent Care from the County?

Have you applied for Medicaid?

Were you denied access to Medicaid benefits?

Have you applied for benefits with the Social Security Administration?

Were you denied benefits by the Social Security Administration?

Have you applied for Supplemental Security Income?

Were you denied Supplement Security Income benefits?

Do you qualify for or participate in any of the following financial assistance programs, including but not limited to those listed below:

- State-funded prescription programs;
- Homeless or received care from a homeless clinic;
- Participation in Women, Infants and Children programs (WIC);

- Food stamp eligibility;
- Subsidized school lunch program eligibility;
- Low income assistance/subsidized financial assistance for housing at a current valid address

Assets

Home: ( ) Rent ( ) Buy ( ) Own Monthly payment $______________

Auto: Year Make Model Monthly payment $______________

Provide copies of all medical bills in or out of Yoakum County: Total Amount $_________

YOAKUM COUNTY HOSPITAL

CHARITY CARE AGREEMENT

I affirm that the information that I have provided in application for assistance through the Charity Care Program is true and correct to the best of my knowledge.

SIGNED:____________________________

PRINTED:__________________________

DATED:____________________________