HENDRICK MEDICAL CENTER

Enclosed is an application from Hendrick Medical Center for assistance with your hospital services only.

Please fill out this form completely and precisely and return it to us in the self-addressed postage paid envelope that we have provided. The application(s) will help us in determining the discount amount you may qualify for.

Please do not leave any blanks unanswered on the form. If some questions do not apply to you or your situation, please indicate with a N/A (non-applicable).

Our guidelines require:

1) Two current check stubs.

2) The prior year complete tax return.

3) Last two months of complete bank statements (all pages) of any open bank accounts (joint and/or individual of checking and savings).

4) If there is not a checking account and pay check is being direct deposited to a debit or pay card a copy of the card is required.

If the applicant has no checking or savings account, please indicate that by putting NONE in the proper space. Do not put a zero (0). The application will not be processed. If you no longer file a tax return please indicate that on the form. Additional Information may be requested once we review the application. Failure to provide any of the required information or to leave unanswered questions on the form could result in a denial of assistance.

Sincerely,

Patient Resource Assistance Dept.
325-670-4160
Hendrick Medical Center
Mabee Building, 1900 Pine St
Abilene, Texas 79601

MRN_____

HENDRICK HEALTH SYSTEM
REQUEST FOR ASSISTANCE

Patient Name_____Phone_____

Social Security #_____DOB_____

Address_____City_____State_____Zip_____

List of family members in the home: _____

NAME	SOCIAL SECURITY	RELATIONSHIP TO PATIENT	DOB	AGE

Guarantor on account: _____Address_____Phone_____

Do you have health insurance?_____ Are the minors on Medicaid and/or Chip? _____

Have you applied for: CIHCP_____Medicaid_____DARS____Other_____ When_____

Have you applied for SSI/SSD? Yes_____ No_____ Date applied_____Pending? Yes_____ No_____

Do you have an attorney? Yes___No___IF YES: **Attorney's Name**_____

Attorney's address and phone #_____

FINANCIAL INFORMATION

INCOME (*Attach Proof of Income*-Application cannot be processed without income)

Name of wage earner:	Place of Employment	Length of Employment	Estimated monthly income
			$_____
			$_____
			$_____

Other Income Source (SSI/SSD, Disability, Social Security Retirement, Other Retirement, VA Pension, Rental Property, Workers Comp, Unemployment, child support, etc.)

_____ $_____

_____ $_____

If no income, how do you meet your living expenses:

_____

_____

CASH AND ASSETS (ATTACH COMPLETE BANK/SAVINGS STATEMENTS)

Checking Balance $_____Savings Balance $_____

Cash Surrender Value of Life Ins $_____

Current Cash Value of Other Liquid Assets: (Stocks, Bonds, CD's, Mutual Funds, etc.) $_____

Auto (1) Year/Make_____Value of Auto $_____

Auto (2) Year/Make_____Value of Auto $_____

Own/Rent Home: _____Other Property Owned: _____

EXPENSES AND LIABILITIES

Living Expenses (Rent/Mortgage, Utilities, Phone, Cable, Auto Pmts, Ins. Premiums, etc.) $_____

HMC Medical Expenses $_____

EXPLAIN CIRCUMSTANCES IN WHICH PAYING THIS HOSPITAL BILL WOULD CREATE A HARDSHIP_____

_____

_____

_____

I certify the above information is accurate & complete. I authorize Hendrick Medical Center to contact employers and to investigate my credit record.

Signature:_____ **Date**_____

Assisted by HMC Rep:_____ **Date**_____