

**HARRIS COUNTY HOSPITAL DISTRICT
APPLICATION FOR FINANCIAL ASSISTANCE**

All first time applicants must have a face-to-face interview at one of the HCHD Eligibility Centers in order to receive financial assistance. If you have had previous financial assistance with HCHD, you may fax, mail, or drop off your application with supporting documents at any Eligibility Center.

Please provide “copies” of all required documentation as requested.

The mailing address is:

HCHD Financial Assistance Program
C/o Patient Eligibility Services
P.O. Box 300488
Houston, TX 77230

the fax number is: (281) 454 – 0527

YOUR RESPONSIBILITIES

You will be asked to bring proof of what you write on your application. If you need help getting proof, the interviewer can assist you in this matter.

Examples of some of the proofs that you will need to provide are as follows:

- **YOUR IDENTITY AND IDENTITY OF FAMILY MEMBERS**

Proofs: Texas Driver’s license or Texas Identification card, student ID with picture, current employee job badge with picture, passport with picture, U.S. Immigration documents with picture, credit card with picture, ID issued by foreign consulates, marriage license, birth certificates, Social Security card, U.S. naturalization, citizenship or other federal documents, hospital or birth records, adoption papers or records, voter’s registration card, or wage stubs.

- **WHERE YOU LIVE AND PLAN TO CONTINUE LIVING**

You will need one proof of residency. **Accepted proofs dated within the past 60 days:** utility bill, credit card statement, mortgage statement; rental verification form, commercial mail addressed to you or your spouse, printout from Texas Workforce Commission, domicile verification form completed by a reliable person not living with you. **Accepted proofs dated within the past year:** Lease agreement, school records for minor children, Department of Motor Vehicle documents, property tax statement, automobile insurance documents, automobile registration, printout from IRS or Social Security Administration, certification documents from Food Stamps, Medicaid, or Chip, letter from recognized social services agency, current voter’s registration card, post office records, and church records.

- **HOUSEHOLD INCOME FOR THE PAST 30 DAYS**

Proofs: Check stubs, wage verification letter, **current year 1040 tax form if self employed**, Pension, child support, Social Security, unemployment, Workmen’s compensation, retirement checks or statements. **If no income, proof of support (statement of support, bank statement, credit card bills etc).**

- **HOUSEHOLD COMPOSITION**

Proofs: birth certificate, baptismal record, death certificate, most recent IRS 1040 form; Social Security Award letter for dependents, school documents, insurance documents, U.S. Immigration application, divorce or child support decree, baby’s Poppra’s form, birth fact record or hospital armband for newborns up to 90 days old, proof of school enrollment for students aged 18-23.

- **IMMIGRATION STATUS**

You do not have to be a U.S. citizen to qualify for financial assistance. However, if you are not a citizen and you have documentation from US Citizenship and Immigration Services, it must be presented to determine your eligibility for assistance.

- **OTHER HEALTH CARE COVERAGE**

Proofs: Insurance ID cards (Medicaid, Medicare, CHIP, CHIP Perinatal) award or claim letters, insurance policies, court documents.

- **RESOURCES**

If you have Medicare coverage and you want to apply for a discount on services and fees not covered by Medicare, you must provide proof of your resources and liabilities (bank accounts, loans, credit cards).

Information on race and sex is voluntary. Information on Social Security Numbers should be given, if available. These types of information will not change your eligibility.

You must give information about medical insurance and other third party financially liable for medical services paid under this program for yourself and members of your household. By signing and submitting this application, you are agreeing to give HCHD the right to recover the cost of health care services provided by HCHD from any third parties.

You may be asked to apply for CHIP, CHIP Perinatal, Medicaid, TANF (Temporary Assistance for Needy Families) or SSI (Supplemental Security Income) benefits. If you are asked to apply for one of these programs, you may still be eligible for assistance from HCHD for a limited period of time. If you are not eligible for these other programs, if you have answered all questions on the application, and if you have given all the proof asked for, your application is complete.

After turning in your application, you must report within 14 days any changes in your address, income, people living with you, or application for (or receipt of) SSI, CHIP, Medicaid, TANF or health insurance. Failure to report these changes may result in losing your assistance from HCHD.

If you are qualified for financial assistance and it is later determined that the information or proof you provided on this application is false, you may lose your financial assistance, may be barred from reapplying for six months, and be required to repay HCHD for any services rendered. You may also be charged with criminal and/or civil penalties.

If you need assistance or to schedule your first time appointment, call (713) 566-6509.



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This is an Official Government Record. Untrue or incomplete information given on this form may and probably will result in Criminal Action being taken under Sections 31.04, 37.04, 37.1, or other portions of the Texas Penal Code.

Applicant's Name: _____ Maiden Name: _____
 Last First Middle

Home Address: _____ Apt #: _____ County: _____
 City: _____ State: _____ Zip Code: _____

Home Telephone #: _____ Work Telephone #: _____ Gold Card #: _____

Marital Status: Single Married Separated Divorced Widowed Common Law

Household Members:

Last Name	First Name	Relationship	Date of Birth	Social Security #	Race	Sex	Employed	Legal Status
		SELF				M <input type="checkbox"/> F <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> Sponsored <input type="checkbox"/> Work Permit <input type="checkbox"/> Visa <input type="checkbox"/> Undocumented
						M <input type="checkbox"/> F <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> Sponsored <input type="checkbox"/> Work Permit <input type="checkbox"/> Visa <input type="checkbox"/> Undocumented
						M <input type="checkbox"/> F <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> Sponsored <input type="checkbox"/> Work Permit <input type="checkbox"/> Visa <input type="checkbox"/> Undocumented
						M <input type="checkbox"/> F <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> Sponsored <input type="checkbox"/> Work Permit <input type="checkbox"/> Visa <input type="checkbox"/> Undocumented
						M <input type="checkbox"/> F <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> Sponsored <input type="checkbox"/> Work Permit <input type="checkbox"/> Visa <input type="checkbox"/> Undocumented
						M <input type="checkbox"/> F <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> Sponsored <input type="checkbox"/> Work Permit <input type="checkbox"/> Visa <input type="checkbox"/> Undocumented

Unemployed? _____ Last Date of Employment: _____ Employer Name: _____

Have you ever received services through HCHD? YES NO

Is anyone pregnant? YES NO

If yes, who? _____ Expected Delivery Date: _____

Does anyone have health insurance? YES NO

If yes, who? _____ Name of Insurance Company: _____
 Member Number: _____

Have you or a member of your household applied for SSI? YES NO

If yes, who? _____ When? _____

Source of income: (Be sure to include all income received)
Wages, Rental Property, Child Support, Alimony, Unemployment Benefits, SSI, RSDI, SSD, Cash Contributions, Workmen's Compensation, Self-Employment (current 1040 income tax), TANF, VA Benefits, Pension, Retirement, Adoption Subsidy, Government Assistance.

Name of person working or receiving money	Source of Income	How often received? (Weekly, Bi-weekly, Twice a month, Monthly)	Amount Received

My signature below authorizes the release of information to HCHD vendors, contractors, state and federal agencies.

Applicant's Signature: _____ **Date:** _____

Witness Signature if applicable: _____ **Date:** _____