

**APPLICATION FOR ASSISTANCE
HARRIS COUNTY HOSPITAL DISTRICT**

All first time applicants must have a face-to-face interview at one of the HCHD Eligibility Centers in order to receive financial assistance. However, 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. Be sure to:

The mailing address is:

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

The fax number is: (713) 566 – 6670

YOUR RESPONSIBILITIES

You may be asked to bring proof of what you write on your application or tell the person interviewing you. If you need help getting proof, the interviewer can assist you in this matter. Or, you can ask to see the Manager at the interview location.

Examples of some of the things you may be asked to prove and things you can use for proof are:

- **YOUR IDENTITY AND IDENTITY OF FAMILY MEMBERS**
Possible proof: Driver's license or Texas Identification card, student ID with picture, 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 coupon; rental verification form; mail addressed to you or your spouse; statement from child care provider; printout from the Texas Workforce Commission; or a domicile verification form completed by a reliable third person. **Accepted proofs dated within the past year:** lease agreements; school records for minor children; Department of Motor Vehicle Insurance documents; property tax statement, automobile insurance documents; automobile registration; printout from IRS checks or from the Social Security Administration; certification documents from Food Stamps; Medicaid or Medicare; letter from recognized social services agency; current voter's registration card; post office records, or church records.
- **HOUSEHOLD INCOME FOR THE PAST 30 DAYS** Possible proof: pay check stubs; pay checks; W-2 tax forms; wage verification letter; current year 1040 tax form; benefit letters; retirement checks or statements.
- **HOUSEHOLD COMPOSITION (who lives with you)** Possible proof: birth certificate; baptismal record; most recent IRS 1040 form; Social Security Award letter for dependents; school documents; insurance documents; U.S. Immigration applications; divorce or child support decree; baby's Popras form; birth fact record or hospital armband; 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 the INS, it must be presented to determine your eligibility for assistance.
- **OTHER HEALTH CARE COVERAGE**
Possible proof: award or claim letters; insurance policies; court document; other legal papers.
- **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.

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 party.

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, AFDC, or Medicaid. 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 and wish to schedule your **first-time** appointment, call (713) 566-6509.

**Harris County Hospital District
Application for Financial Assistance**



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)

Social Security Number: _____ Birth Date: _____

Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Home Telephone #: _____ Work Telephone Number: _____

Cell Phone Number: _____ Emergency Contact Number: _____

Sex: M F Marital Status: Single Married Separated
Divorced Widowed

(Check appropriate box) New Applicant Renewal Gold Card Number _____

Have you ever received services through HCHD? Yes No

Is anyone pregnant? Yes No Does anyone have health insurance? Yes No

If yes, who Expected Delivery Date _____ Name of Insurance Company: _____
Member Number: _____

Have you had a work-related accident? Yes No

Household Members (List additional members on a separate sheet of paper)

Last Name	First Name	Relationship	Date of Birth	Social Security #	Employed	Legal Status	Gold Card
		SELF			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Sponsored <input type="checkbox"/> Work Permit/VISA <input type="checkbox"/> Undocumented	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Sponsored <input type="checkbox"/> Work Permit/VISA <input type="checkbox"/> Undocumented	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Sponsored <input type="checkbox"/> Work Permit/VISA <input type="checkbox"/> Undocumented	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Sponsored <input type="checkbox"/> Work Permit/VISA <input type="checkbox"/> Undocumented	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Sponsored <input type="checkbox"/> Work Permit/VISA <input type="checkbox"/> Undocumented	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Sponsored <input type="checkbox"/> Work Permit/VISA <input type="checkbox"/> Undocumented	<input type="checkbox"/> Yes <input type="checkbox"/> No

Sources of Income (check all that apply):

Employed Check Stubs Cash

Self-Employed/Rental Property 1099 1040 Do not file taxes Last income tax return filed: _____

Unemployed Last Date of Employment _____ Unemployment benefits Workmen's Compensation No income

Cash contributions: How much? \$ _____ How often? _____

Child Support/Alimony: How much? \$ _____ How often? _____

Social Security/Disability: SSI SSDI RSDI Employer How much? \$ _____ How often? _____

Pension/Retirement How much? \$ _____ How often? _____

VA Benefits: How much? \$ _____ How often? _____

TANF: How much? \$ _____ How often? _____

Other: Government assistance Educational assistance Crime Victim's Adoption Subsidy

Signature of Applicant: _____ Date: _____

Signature of Co-Applicant: _____ Date: _____