



**HARRIS COUNTY HOSPITAL DISTRICT
PATIENT ELIGIBILITY SERVICES
NOTIFICATION OF DENIAL FOR FINANCIAL ASSISTANCE**

Patient Name: _____ CPI: _____

Application Number: _____ Eligibility Center: _____

Date Denied: _____ Interviewer: _____

We regret to inform you that your application for financial assistance from HCHD has been denied. This decision was made based on the information you provided in your application. Specifically, you do not qualify for financial assistance for the following reason(s):

- _____ You are not a resident of Harris County.
- _____ HCHD is not contracted with your HMO or insurance plan.
- _____ You have selected a Primary Care Provider (PCP) that is not in the HCHD network.
- _____ Your income exceeds the limit for financial assistance.
- _____ Your assets exceed the limit for financial assistance.
- _____ You did not return the items necessary to complete your application within the specified timeframe.
- _____ Other (specify) _____

You may receive health care from HCHD but you will be expected to pay 100% of all charges. You may re-apply for financial assistance at any time. A copy of eligibility policies is available upon request at any eligibility center.

If you disagree with this decision, you may ask to speak to the manager of this eligibility center. If the manager is unable to resolve the problem to your satisfaction, you may submit an appeal to the Eligibility Appeals Committee or file an appeal to the County Court of Harris County.

Free legal representation may be available from the Legal Aid Society of the East Region of Texas, 1415 Fannin, Houston, TX 77002, Phone: (713) 495-1954.

SUGGESTIONS

- Out of county residents – may want to contact John Sealy Hospital, 301 University St., Galveston, TX, telephone (409) 772-6266 or your County Indigent Health Care Program.
- Clients with an HMO Plan where the PCP is not a provider with the Harris County Hospital District should see their PCP for treatment.

APPEALING OUR DECISION

To appeal a decision about your financial assistance application to the HCHD Eligibility Appeals Committee, please complete the information below. This form must be completed within 65 days of your visit to the eligibility center. **Please submit any documents you have to support your appeal with this form.**

I wish to appeal the eligibility center’s decision for the following reason:

Patient Signature: _____ Date: _____

Completed form should be mailed or faxed to:
Eligibility Appeals Committee
Harris County Hospital District
c/o Director, Patient Eligibility Services Administration
2525 Holly Hall, Suite 200
Houston, TX 77054
Phone: (713) 566-6691
Fax: (713) 566-6670

Once we receive your appeal, your application for financial assistance and any documents we receive from you will be reviewed. You will receive a response within 60 days from the receipt of your appeal.