

This application cannot be filled out on line. It must be printed and mailed to the RESOURCE ASSISTANCE DEPT., 1900 PINE ST., ABILENE, TEXAS 79601 with PROOF OF INCOME.

MRN _____

**HENDRICK HEALTH SYSTEM
REQUEST FOR ASSISTANCE**

Patient Name _____ Phone _____

Social Security # _____ DOB _____

Address _____ City _____ State _____ Zip _____

List of family members in the home: _____

<u>NAME</u>	<u>SOCIAL SECURITY</u>	<u>RELATIONSHIP TO PATIENT</u>	<u>DOB</u>	<u>AGE</u>
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_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____
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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

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 _____

*The Resource Assistance unit of **Hendrick Medical Center** approves Income Based Discounts for **Hendrick Medical Center charges only**. All other healthcare providers will bill you separately and have their own policies about how their bills are handled. Hendrick Medical Center's approval for an Income Based Discount **does not entitle** you to a discount on any other medical bills or physicians charges even if related to a **Hendrick Medical Center visit**.*