Hill Country Memorial
Financial Assistance Application
Fredericksburg, TX

Patient Name: _____

Patient Social Sec #: _____ Patient Date of Birth: _____
Does Patient Have Insurance Coverage (Y, N) _____ Carrier/Company? _____

Responsible Party name (if different than patient): _____

Social Sec # _____ Date of birth: _____ Relationship to patient: _____
Address: _____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Marital Status: Single___ Married ___ Widowed___ Divorced___ Employed: Y __ N __
Employer: _____ Occupation: _____ How Long? _____

Spouse/Partner Name: _____ Spouse Social Sec#: _____
Date of birth _____
Employed: Y __ N __
Spouse Employer Name/Address: _____ Occupation: _____ How Long? _____

Household Family Information: Size (_____) **(Please list all dependents Below)**

Name	Relationship	Gross Monthly Income	Date of Birth

Any Additional Family Household Income: $_____ (e.g. Rental Income, Child Support, etc.)
Total Gross Family Household income: $_____

(If you answer yes to any question listed below please provide supporting documentation)

Is anyone in your household receiving SNAP, TANF/AFDC, or WIC benefits Y__ N__
Is anyone in your household eligible for the subsidized school lunch program Y__ N__
Is anyone in your household eligible for any state or local assistance programs (e.g. Medicaid spend-down)Y__ N__
Are you eligible for low income/subsidized housing Y__N__
Is anyone in your household eligible for any state- funded prescription programs Y__N__
Are you eligible for charity services at the Good Samaritan Clinic Y__N__
Have you declared bankruptcy in the last 12 months Y__N__

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I understand that the information Submitted is subject to verification. In the review process, additional information may be requested to verify the information provided in this Application. I understand that falsification of information submitted may jeopardize my consideration for the Financial Assistance program.
Furthermore, to qualify for this program, I understand I must be screened for any and all assistance that may be available to help pay this hospital bill prior to completing this application.

Responsible Party Signature _____ Spouse Signature _____ Date _____

Hill Country Memorial Representative _____ / _____ Date _____

Approved _____ **Denied _____** **Date _____**

Revised: January 2019