Harris County Hospital District

service FIRST

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

There is No Fee for a Gold Card. If you are asked to pay for a Gold Card, please report this to 713-566-6277.

Applying for Financial Assistance: Call (713) 566-6509 to schedule an appointment or

Mail to
HCHD Financial Assistance Program
P.O. Box 300488
Houston, TX 77230

or Drop off to the nearest Eligibility Center

Please provide copies of the following papers:

- **Identification (ID) (One for you and your spouse)**
  State issued driver's license, state issued ID card, current student ID with picture, current employee job badge with picture , passport with picture, U.S. Immigration documents with picture, credit card with picture, foreign consulate ID card with picture. If picture ID is not available, two of the following proofs may be used: birth certificate (not for married women), marriage license, social security card, other federal documents showing identity, hospital or birth records, adoption papers or records, voter's registration card, current wage stubs, Medicare card or current Medicaid.

- **Address**
  One proof of address that shows your name or your spouse's name dated within the last 60 days:
  Utility bills, school record for children under age 18, mortgage coupon, credit card statement, printout from IRS of most current year's tax filing, certification documents or benefit checks from Social Security Administration or Texas Workforce Commission, certification documents from SNAP (Supplemental Nutrition Assistance Program, formerly known as food stamp), Medicaid or Medicare, letter from recognized social services agency, business mail, statement from a licensed child care provider, Harris County Hospital District Residence Verification Form completed by a reliable person not living in the same household or Harris County Hospital District Rental Verification Form completed by landlord.
  OR
  One proof of address that shows your name or your spouse's name dated within the past year:
  Current lease agreements, department of motor vehicles record, property tax documents, automobile insurance documents (non expired), automobile registration or voter's registration card for current year.

- **Income for the past 30 days of each household member**
  Current check stubs, child supports, current IRS 1040 tax return, Harris County Hospital District Statement of Self Employment Income Form, Harris County Hospital District Wage Verification Form, Social Security, Retirement or Veteran Affairs letter or check, unemployment benefit records or Harris County Hospital District Statement of Support Form if no income.

- **Household members (one for each)**
  Birth certificate, baptismal record, proof of full time school enrollment for students aged 18 to 23, Social Security Award letter with dependent's names, school documents or insurance documents showing names of parent and child, U.S. Immigration applications with dependents' names, divorce or child support decree, baby's Popras form, birth fact record or hospital armband for infants under 90 days old, current Medicaid or Death Certificate for previous household members.

- **Immigration Status (for each household member)**
  You must bring documents from the U.S. Citizenship and Immigration Services.

- **Health Care Coverage (for each household member)**
  Please bring current proof of Medicaid, CHIP, CHIP Perinatal, Medicare or health insurance.

- **Resources for Medicare patients**
  You must provide proof of your resources and liabilities (current bank statement, credit card bills, loans, etc.) on a Medicare Asset Form.

*You must apply for CHIP, CHIP Perinatal, Medicaid, TANF (Temporary Assistance for Needy Families) or SSI (Supplemental Security Income) benefits if you qualify.
If you need help getting proof, the interviewer can help you.

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APPLICATION FOR FINANCIAL ASSISTANCE

This is an Official Government Record. False or incomplete information given on this form may result in criminal action being taken under Sections 31.04, 37.04, 37.10, or other portions of the Texas Penal Code.

There is No Fee for a Gold Card. If you are asked to pay for a Gold Card, please report this to 713-566-6277.

Name: ____________________ _____________ _____________ **Maiden Name:** ___________________________

Home Address: ____ **Apt #:** _____ **County:** ____________________

City: ____ **State:** _____ **Zip Code:** __________________

Home Telephone #: ________________ **Work Telephone #:** ________________ **Patient Identifier #:** _________________

Martial Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Common Law**

Have you ever been to Ben Taub, LBJ or Quentin Mease Hospitals? ☐ Yes ☐ No If yes, when? _________________________

Household Members:

Last Name	First Name	Relationship	Date of Birth	Social Security #	Race	Sex	Employed	Legal Status	
		SELF				☐ M ☐ F	☐ Yes ☐ No	☐ US Citizen ☐ Legal Resident ☐ Undocumented	☐ Work Permit ☐ Sponsored ☐ Visa
						☐ M ☐ F	☐ Yes ☐ No	☐ US Citizen ☐ Legal Resident ☐ Undocumented	☐ Work Permit ☐ Sponsored ☐ Visa
						☐ M ☐ F	☐ Yes ☐ No	☐ US Citizen ☐ Legal Resident ☐ Undocumented	☐ Work Permit ☐ Sponsored ☐ Visa
						☐ M ☐ F	☐ Yes ☐ No	☐ US Citizen ☐ Legal Resident ☐ Undocumented	☐ Work Permit ☐ Sponsored ☐ Visa
						☐ M ☐ F	☐ Yes ☐ No	☐ US Citizen ☐ Legal Resident ☐ Undocumented	☐ Work Permit ☐ Sponsored ☐ Visa
						☐ M ☐ F	☐ Yes ☐ No	☐ US Citizen ☐ Legal Resident ☐ Undocumented	☐ Work Permit ☐ Sponsored ☐ Visa

Household Income: (include all income in the family)
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 getting money	Source of Income/Company Name	How Often? (weekly, bi-weekly, twice a month, monthly)	Amount

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 #: ______________________

Have you or a member of your household applied for SSI? ☐ Yes ☐ No If yes, who? ___________________ When? ________

Unemployed? ☐ Yes ☐ No Last day worked: ___________________ Name of Company: ____________________

You must report any changes of name, address, marital status, legal status, income, household members, and health care coverage immediately. Failure to report these changes may result in losing your assistance from HCHD and/or being responsible for repayment of the costs incurred by HCHD in providing your medical care.

I certify under penalty of law that the information I have provided to HCHD is true and complete to the best of my knowledge. My signature authorizes the release of information to HCHD vendors, contractors, state and federal agencies, or patient assistance programs to review records for auditing purposes.

Signature:	**Date:**
Witness Signature (if applicable):	**Date:**