**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 |
|---|---|---|---|
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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