CUERO REGIONAL HOSPITAL

FINANCIAL ASSISTANCE/CHARITY APPLICATION

Contact Cuero Regional Hospital Financial Counselors to assist with question on this application.
(361) 275-6191 ext. 2420

Account(s):____
Initial Application Date: ________________________ Total Balance Due: _________________________
Cuero Regional Hospital Account Totals, reflected in the accounts listed
Home Phone: _________________Cell Phone: ____________________Work Phone: _______________
Patient # (MRN) _______________________________

Do you live within the Cuero Regional Hospital District? Yes______No_______
Date of Birth:__________Male_________Female_____Social Security Number______________________
Ethnicity_____________________________ Last Year of education complete__________________
Place of Birth__________________________________
Are you U.S. Citizens? Yes______No_______ *(City, State or Country)*
Mothers Maiden Name______________________ Repeat Cuero Patient? Yes_______No_______

Patient Account Registration Details
(to be completed by the Financial Counselor or Liaison)

Account Reg. #	Date of Admission	Visit Amount	Account Reg. #	Date of Admission	Visit Amount
					Total Visit Amount:	

Household Members

Please provide the full name and date of birth for all members. Please include Social Security Number and relationship if known.
Applicants' Social Security Number and Date of Birth are required

Name	Date of Birth	Sex	Social Security #	Relationship to Applicant
		____M_____F		Self
		____M_____F		
		____M_____F		
		____M_____F		

Household Income Information

Include all sources of income (wages). Only earned income should be noted here.

Household Member	Employer & Location *(Address if available)*	Amount	Period	State Date	End Date *(if Applicable)*
Total Monthly Household Income:					

CUERO REGIONAL HOSPITAL CUEROHEALTH

CUERO REGIONAL HOSPITAL

FINANCIAL ASSISTANCE/CHARITY APPLICATION

If none, how are you housing and transportation needs met? Please explain.:_________________________________

Unearned Income

Unearned income such as Social Security benefits, Alimony, Child Support, Pension, Retirement, etc. should be listed here

Household Member	Unearned Income Type	Amount	Period
	Total Unearned Income- Monthly		

Household Expenses

Please provide details for all current household expense. Please include the monthly totals.

Type of Expense	Monthly Amount	Period	Type of Expense	Monthly Amount	Period
1)			3)		
2)			4)		

Total Expenses-Monthly:________________(This total will count as deductions)

If no mortgage or rent, source of housing:____

Medical Expenses for the Aged & Disabled

Please provide details for all current medical expenses for the aged & disabled. Please include the monthly totals.

Type of Expense	Average Payment	Period	Type of Expense	Average Payment	Period

Loans and Other Expenses

Please provide details for all current loans & other expenses. Please include the monthly totals

Type of Expense	Average Payment	Period	Type of Expense	Average Payment	Period

Assets/Resources

Please provide details about all Assets/Resources for the household. Please include Home, Property, and Vehicles

Household Member	Asset/Resource Type *(Make, Model, Year of Vehicles-Address for property)*	Estimated Value	Additional Account Holder(s) *(If Applicable)*

CUERO REGIONAL HOSPITAL

FINANCIAL ASSISTANCE/CHARITY APPLICATION

Health Insurance Please provide information on any CURRENT health insurance or state program (i.e. Medicaid, CHIP, Medicare, FHP, etc.) Please include policy numbers and note which household members are covered if applicable.				
Policy Holder Name	Policy Name Or State Program Name	Address (if Known/Applicable)	Policy Number	Household Members covered under Policy

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I agree to tell the provider of services, within 10 days, if there are any changes in my (or my persons on whose behalf I am acting) income, property ,expenses, or in the person in the household or of any changes of address.
- I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with my employer, bank, credit verification and property searches.
- I understand that the county and hospital are required by law to keep any information I provide confidential.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county or hospital from proceeds of any litigation or settlement resulting from such act.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the changes of the services rendered by the Hospital or I may appeal decision in writing with additional documentation.

I affirm that the information included on this application is true, complete, and correct to the best of my knowledge

Signature: X____ Date:_______________________________________

Financial Counselor Name:_____________________________ Phone Number:____________________________

If applicable:
Authorized Representative Name:____

Authorized Representative Signature_______________________________Date:__________________________

FOR HOSPITAL USE ONLY:
LIABILITY COMPUTATIONS
Total Net Real and Personal Property Monthly Payment (A) _____________________________
(+) Total Monthly Gross Income (B) _____________________________
TOTAL MONTHLY INCOME _____________________________
(-) Total Monthly Deductions (C) _____________________________
Other qualified payer sources, if any: _____________________________

Signature____Date__________________________________