Val Verde Regional Medical Center
Charity Application/Aplicacion De Caridad

Patient Name/Nombre del Paciente:	
Date of Birth/Fecha de Nacimiento:	SSN/Numero de seguro social:
Address/Domicilio:	
Phone#/Telefono:	Marital Status/Estado Civil:

Please circle one/Seleccione uno:

Citizenship/ciudadania: US MX Undocumented Legal Resident_____(Year/Ano)

Minors/Menores:	Pregnant/Embarazada: YES NO (Date/Fecha)_____ CHIP: YES NO

Living arrangements/Vivienda:	Monthly payment/Pagos mensuales:	How long:_____ Cuanto tiempo:

PATIENT EMPLOYMENT INFORMATION/INFORMACION DE EMPLEO DEL PACIENTE

Current Employer/Empleo:	Last day/Ultimo dia:
Address/Domicilio:	How long:_____
Phone#/Telefono:	Rate/Cantidad: $ HR/WK/M
How often paid/Cada Cuando le pagan:	Other payments/Otros pagos:

SPOUSE EMPLOYMENT INFORMATION/EMPLEO DE ESPOSO(A)

Name/Nombre	SSN/#Social	DOB/Nacimiento:
Current Employer/Empleo:		Last day/Ultimo dia:
Address/Domicilio:		How long:
Phone#/Telefono:	Rate/Cantidad: $	HR/WK/M
How often paid/Cada Cuando le pagan:	Other payments/Otros pagos:	

HOUSEHOLD MEMBERS/MIEMBROS DEL HOGAR

Name/Nombre	SSN/Numero de seguro Social	Age/Edad
Disability/Discapacidad:	Family Support/Apoyo Familiar:	

I authorize the verification of the information provided on this form as my rescources and employment. I certify I have given correct information for this application process. I understand I need to meet policy and guidelines in order to qualify for this charity discount.

Autorizo la verification de la informacion proporcionada en este formulario como mis recursos y empleo. Certifico que he proporcionado informacion correcta para este proceso de solicitud. Entiendo que necesito cumplir con las pautas de poliza para calificar para este descuento de la caridad.

Signature/Firma del Paciente:	Date/Fecha:

Hospital Financial Assistance Application

I understand that this application is made in order that Val Verde Regional Medical Center can judge my eligibility for uncompensated services. If any information I have given proves to be untrue or is withheld, I understand that the hospital may re-evaluate my financial status and take whatever action is deemed to be appropriate to include denying this application in its entirety now and any future applications.

I/We certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges, and I/we will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

_____ _____

Guarantor Signature/Firma del Paciente **Date/Fecha**

_____ _____

Spouse Signature/Firma del Esposo/a **Date/Fecha**

I, the undersigned, state, under oath and under penalty for perjury, that I have personal knowledge of the facts stated in the attached application and they are true and correct.

_____

Signature/Firma del Paciente

SUBSCRIBED AND SWORN TO before me, the undersigned Notary Public, on this the _____ day of _____, 20____.

Commission Expires **Notary Public In and For The State of Texas**

_____ _____