

APPLICATION FOR CHARITY/FINANCIAL ASSISTANCE

PLEASE PRINT:

Today's Date:	I I			
	mm dd yy		Med Re	c#
Patient Name:	Last	First		M.I.
Responsible Party if not Patient:				
	Last	First		M.I.
Patient Address:		Street		Apt#
	City	County	State	Zip
Home Phone:		Work Phone:		
Area	Code	Area Code		
Email Address:				
Patient Social Security Number:				
Patient Date of Birth:	I I mm dd yy	Date of Service: I I mm dd y	у	
I. Automatic Quali	fication			
Were you an active at the time of your s	_	y Assistance or Medicaid Yes	No	
Uovo von anbaoano	ntl y hagama aligible f	For Medicaid? Ves	No	



Do you receive any government low-income subsidies, such as SSI, SNAP, Texas CEAP, NSLP, WIC, TANF, Ector County Welfare?

SSI:	Yes	No
SNAP:	Yes	No
Texas CEAP:	Yes	No
NSLP:	Yes	No
WIC:	Yes	No
TANF:	Yes	No
Other	Yes	No

If you answered yes to anything listed in Section I, do not complete Section II.

H. Annual Income

Please list all family members (including you). Family members include the applicant, their spouse, and children (natural or adoptive) under the age of 18 living in the home along with the applicant. Income includes gross (pretax) wages, rental income, unemployment compensation, Social Security benefits, public assistance, etc.

Family Members	Age	Relationship to Patient	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service
1.					
2.					
3.					
4.					
5.					
6.					

Patient/Guarantor Signature:	Date Completed:
By my signature below, I certify that I have careful stated or provided in any attachment is true and counderstand that it is unlawful to knowingly submit for the state of th	rrect to the best of my knowledge and belief. I
* Must attach proof of income	
Average Patient/ Family income	
0.	

If you have questions or need assistance with this application, please call the TTUHSC Permian Basin Business Office at 432-703-5042.