Seton Medical Center Harker Heights

Financial Assistance Application

Thank you for choosing the Seton Medical Center Harker Heights. The Seton Medical Center Harker Heights is a Catholic healthcare ministry whose mission inspires us to care for and improve the health of those we serve with the special concern for the poor and the vulnerable. In support of our mission, we provide financial assistance to patients who cannot afford medical care.

If you are unable to pay for the medical services you receive, you can apply for financial assistance. Seton Healthcare Family will review your application to determine if you or your family member qualifies for governmental assistance such as Medicaid, community assistance, or financial assistance.

Financial assistance for medically necessary services is limited and is not intended to replace reasonable financial planning, health insurance coverage, or available public funding for which you may qualify.

Instructions for completing this application:
Please complete the attached Financial Assistance Application and provide the required documentation listed below. Please ***do not leave any items blank!*** Your application cannot be processed if the information provided is incomplete.
Your application will be evaluated according to Section 311 of the Texas Health and Safety Code as well as the guidelines set forth by section 501-R of the Affordable Care Act. We are required to determine your eligibility for assistance based upon federal poverty guidelines and all sources of income for you and your family. In some cases, we are required to consider your financial resources, assets, and non-exempt property in addition to income.

Accordingly, we require that you provide the following documentation regarding your application. Proof of income from every household member must be included before we can process the application. If you do not have a document, please indicate N/A next to the missing document. Any information received is subject to verification.

Please provide all that apply:

_____Most recent Income Tax Return for each working family member [*Previous year's return accepted through* ***April 15th***]
Ex: 2015 Tax Return will be accepted through April 15th of 2017

_____Check Stubs; ***three*** *most recent pay periods for <u>each</u> working family member*

_____Letter from employer on company stationery confirming income amount stated on application

_____Letter from unemployment office

_____Letter from Social Security Office or copy of Social Security check

_____Documentation on any other forms of Income; *Child Support, Alimony, Retirement Income, Trust Funds, etc.*

_____Letter of determination for any publicly funded programs or third party payment sources; *MAP, Medicaid, Motor Vehicle Accident Liability Determination, etc.*

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_____Letter of determination for government assistance programs; *Food Stamps, WIC, Subsidized Housing, etc.*

_____Letter of support from family member, friend, etc.

_____ Official school transcript

If you are enrolled in one of the Government Assistance programs listed on the Financial Assistance Application, you do not need to provide proof of income information <u>other than</u> proof of enrollment or award letters associated with the Government Assistance Program.

If you have questions or need assistance completing this form, please direct your calls as indicated below:

- For local calls dial (844-886-1798)

Please mail this form, along with your completed Financial Assistance Application, to the address below:

Seton Medical Center Harker Heights
850 W. Central Texas Expressway
Harker Heights, TX 76548
Attn: Patient Financial Services

Once all information is provided, your application will be processed and notification of the determination will be mailed to the guarantor address on file. Your Financial Assistance eligibility will be upheld for 30 days. More than 30 days past the initial application, you must reapply for any additional assistance needed. Similarly, if you are applying for financial assistance retroactively, your eligibility determination will apply to any outstanding balances.

Financial Assistance Application

Seton Acct. #(s):	Acct. Balance(s):	MRN(s):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name: _____

Social Security # _____ **Date of Birth:** _____ **Marital Status:** _____

Guarantor: _____ **Guarantor's Social Security #:** _____

Street Address: _____ **Phone #:** _____

City: _____ **County:** _____ **State:** _____ **Zip Code:** _____

Income Information

# of Dependents: _____ **Number of Individuals Receiving Income:** _____ **Monthly Gross Wages: $**_____

Monthly Unemployment: $_____ **Monthly Child Support: $**_____ **Monthly Alimony: $**_____

Trust Fund Receipts: $_____ **Monthly SSI Benefits: $**_____ **Other Monthly Income: $**_____

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TOTAL MONTHLY INCOME $_____

SUPPORTING DOCUMENTATION MUST BE PROVIDED FOR EACH TYPE OF INCOME LISTED

Government Assistance

Please *CHECK* all that apply

☐ **Food Stamps** ☐**WIC (Women, Infants, and Children)** ☐**Subsidized Housing**

☐**MAP** ☐**CCHC** ☐**Texas Medicaid/CHIP** ☐**Medicaid (a state *other than* Texas): _____**

☐ **County Indigent Care Program (county name):_____**

☐ **Seton Care Plus (SCP)** ☐ **Music Seton Care Plus (MSCP)**

SUPPORTING DOCUMENTATION MUST BE PROVIDED FOR EACH TYPE OF ASSISTANCE CHECKED

Asset Information Section

Include *all* applicable values

☐ **Stocks**	**Value$_____**	☐**Bonds**	**Value$_____**
☐**IRAs**	**Value$_____**	☐**Secondary Residence**	**Value$_____**
☐**Boat**	**Value$_____**	☐**Collector Automobiles**	**Value$_____**
☐**RV**	**Value$_____**	☐**Non-Essential Automobiles**	**Value$_____**
		☐**Other Luxury Items**	**Value$_____**

TOTAL VALUE OF ASSETS $_____

CERTIFICATION: I certify to the best of my knowledge and believe the above information is true, correct, and complete. I understand that the information may be disclosed for uncompensated care reporting purposes.

Patient/Guarantor Signature: _____ Date: _____

Completed by: _____ Date: _____