



HCM

HILL COUNTRY MEMORIAL

Hill Country Memorial Financial Assistance Application Fredericksburg, TX

Patient Name: _____

Patient Social Sec #: _____

Does Patient Have Insurance Coverage (Y, N) _____

Patient Date of Birth: _____

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 Name: _____

Spouse Social Sec#: _____

Date of birth _____

Employed: Y ___ N ___

Spouse Employer Name/Address: _____ Occupation: _____ How Long? _____

Household Family Information: Size (____)

(Please list all Family Household Members Below)

Name	Relationship	Gross Monthly Income	Social Security Number	Date of Birth

Any Additional Family Household Income: \$ _____

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 _____

