HCM | HILL COUNTRY MEMORIAL

# Financial Assistance Application (Instructions)
Fredericksburg, TX

Dear Patient/Responsible Party,

We are providing this application because you may qualify for our Hill Country Memorial Financial Assistance Program.

To be eligible for this program, you must demonstrate in writing and by providing proof if requested that your ability to pay your hospital bills is limited. If appropriate to your situation, you must have been screened for Medicaid, State, Local Assistance, or any other third party program and have been denied or otherwise exhausted your current insurance benefits.

The attached application form only applies for Hill Country Memorial Hospital facilities. Services from providers not associated with or employed by Hill Country Memorial are separate from this program, including medical bills you may have from other providers such as, non-Hill Country Memorial physician's, radiologists, pathologists, ambulance services, etc. A complete list of covered providers may be obtained by visiting our website at hillcountrymemorial.org

In order to be considered for financial assistance, you must complete all requirements in the steps below for the Financial Assistance Application. Please allow ten (10) business days for our review process. We will notify you of our determination by letter.

**REQUIRED INFORMATION for the Application:**

- **Patient Information**
  Need to include the specific information about the patient and his/her hospitalization
- **Responsible Party Information**
  This may be the patient. Need to include the information requested for responsible party and spouse if applicable. Address and employer specific information is important.
- **Family Household information**
  The number of persons in the household is important to determine if the patient will qualify. Each additional household member should be listed.
- **Earning and other income information**
  Income information helps determine if the patient will qualify. Information is required, please list all sources.
  Please specify if you/the patient are receiving any sort of other financial assistance.
  Please describe any other means you/the patient are meeting day-to-day living expenses.
- **Signatures and Date are required.**

**Account total charge is $7500 or less-**
Please complete and sign the application. The Responsible Party signature will be the requirement needed to certify that the information being provided is accurate and determine eligibility.
**Account total charge is $7501 or greater –** Please complete and sign the application. Actual, written proof examples are required to complete the application and determine eligibility.
**Medicare Recipients (regardless of account balance) –**
Written proof of information will be required if you receive Medicare Benefits.

Examples of Written Proof include:

1) A couple of your most recent Federal Income Tax Returns
2) Proof of income earned or financial assistance received during the last 12 months
   Written proof examples are:
   a) Employer Pay Stubs or Letter from employer stating earnings each month
   b) Written documentation from income sources
   c) Financial assistance received from the Social Security Administration, AFDC, or Texas Employment Commission
   d) Financial statements from a Certified Public Accountant for self-employed income
   e) Proof of scholarships awarded or loans received
   f) Affidavit of Support (for foreign students only). Note: Sponsors will be contacted to determine their ability to assist with payment of the hospital bill.
   g) If you have no earned or other income or have not filed a tax return in the last 12 months, you may need to provide a form letter 1722 from the Internal Revenue Service at 1-800-829-1040.

## If you need help completing this application, please call one of the numbers listed below:

| | |
|---|---|
| Financial Counselor | (830) 997.1428 |
| Customer Service | (830) 997.1260 |
| Last Name Begins With: | |
| A-Z | (830) 990.6630 |
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