Nacogdoches Memorial Hospital
Financial Assistance Information

Thank you for choosing Nacogdoches Memorial Hospital as your healthcare provider. We are contacting you to inform you of our Financial Assistance program.
Outlined below is some basic information about our Financial Assistance Program.

Purpose of Program

- This program is designed for applicants who have incurred or will incur serious medical expense and lack the means to take care of it financially.
- This program is designed as a one-time assistance for residents financial need and may cover all or a portion of the cost.

Requirements

- Nacogdoches county resident
- Income meets eligibility requirements set by Memorial's eligibility system
- Service requested is covered under Memorial's program.
- One-time spell of illness

Application Process

- Complete the attached application and provide all supporting documents
- Call Memorial's Financial Counselor at 568-8497 to schedule an appointment
- Applications for financial assistance are considered by appointment only.

Questions

If you would have any questions regarding the application process or need assistance in completing the application, please contact Memorial at 568-8497.

NACOGDOCHES MEMORIAL HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

Applicant's Name:_____

Birth Date:_____ Social Security Number:_____

Home Address:

Mailing Address (if different):_____

Home Telephone Number: _____Work Telephone Number:_____

Name of Employer:_____ Hire Date:_____

1. List everyone that lives with you, whether or not you consider them household members.

	Name	Relation To You	Date of Birth	Social Security
a.				
b.				
c.				
d.				
e.				
f.				

2. How many cars, trucks, or other vehicles does your household have? _____

	Year	Make	Model
1.			
2.			
3.			
4.			
5.			

3. Does anyone in your household get cash, gifts, loans, or contributions from parents, relatives, friends, or other? ___Yes ___ No

4. Does anyone living with you get other money, cash, or checks such as grants, loans, child support, unemployment, government checks such as social security, etc? ___Yes ___ No

5. List all of your household income:

Name of Person Working Or Receiving Money	Employer	How Often Received	Amount Received
a.			
b.			
c.			
d.			

6. What is the total income that your household will receive this month? $_____

7. Does anyone in your household have health insurance? ___ Yes ___ No

8. Does anyone in your household pay legally obligated child support to someone who does not live with you? ___ Yes ___ No

9. Does anyone have monthly medical costs such as bills or medicine?
___ Yes ___ No
If "yes" please list:_____
_____

10. Please check one of the following that best describes your living arrangements.

___ Renting ___Own ___ Live with Parents
___ Paying for Home ___ No Permanent Residence

11. List expenses below:

Monthly Rent or Payment	$_____	Monthly Utilities	$_____
Telephone Bill	$_____	Tax on Home	$_____
Home Insurance	$_____	Auto Insurance	$_____
Other Expenses	$_____		

12. Give your household's county and state of residence.

County_____ State_____

13. Do all the listed people who want assistance plan to stay in this county and state as residents?
___ Yes ___ No

The statements that I have made including my answers to all questions are true and correct to the best of my knowledge and belief. I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, handicap, or political belief. I may request a review, orally or in writing of the decision made on my application about actions affecting receipt of assistance.

I understand that by signing this application, I am giving the county the right to recover the cost of health care services provided by the county from any third party. I agree to give the county any information it needs to identify and locate all other sources of payment of health care services. I have been told and understand that my failure to meet the obligations set forth may be considered willful withholding of information and can result in the recovery of any loss by repayment or by filling criminal or civil charges against me.

BEFORE YOU SIGN, BE SURE EACH ANSWER IS COMPLETE AND CORRECT.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Witness/Financial Counselor Date

- MEDICAL ASSISTANCE
- FINANCIAL ASSISTANCE

List of Verification Documents

IDENTITY: **(at least two)**

- Social Security Card
- Driver's License
- Voter's Registration
- Employee Identification Badge
- Birth Certificate
- School Records- Transcripts
- Marriage License or Common Law Letters
- Identification (I.D.) Cards

RESIDENCY: **(at least two)**

- Two receipts showing six months prior residency.
- Current phone bill with your address.
- Current utility bill with your address.
- Current rent receipt or if you own your home or property a copy of Tax Appraisal.
- Current Social Security Check Stub or Social Security Award Letter with address.
- Two Third party notarized sole support letters with current and six month's receipts of who is sole supporter. (Should state length of stay in residency and if person contributing to household expense.)

MONTHLY INCOME:

- Proof of employment- Paycheck Stubs or Retirement income information
- Texas Employment Comm. Card showing actively seeking employment and Texas Employment Comm. Letter of unemployment benefits.
- Medicare Card and current Social Security Award Letter.
- Current Medicaid Card
- Previous year income tax return.
- Veteran's benefit- letter from V.A. showing amount of money patient is receiving.
- Railroad Retirement- current Social Security Award Letter and/or proof or any other Railroad Benefits.
- Letter from employer or previous employer's name, address, telephone number, length of employment and money earned.