Your life. Our Calling.
PETERSON
REGIONAL MEDICAL CENTER

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION

Patient Name	DOB	Medical Record #	
Home Address City State Zip Code			Rent Own Other Live with Parents
Social Security No.	Telephone No.	Marital Status	Does patient have access to GROUP health insurance? Y N
Employer Name		Employer Telephone No.	
Employer Address	Position/ Title	How Long Employed	

RESPONSIBLE PARTY INFORMATION (if different from Patient)

Responsible Party Name	DOB	
Home Address City State Zip Code		Rent Own Other Live with Parents
Social Security No.	Telephone No.	Marital Status
Employer Name	Employer Telephone No.	
Employer Address	Position/ Title	How Long Employed

SPOUSE INFORMATION

Spouse Name	DOB	Social Security No.
Employer Name	Employer Telephone No.	
Employer Address	Position/ Title	How Long Employed

DEPENDENT INFORMATION

Name & age of all children living in the household

MONTHLY INCOME				MONTHLY EXPENSES			ASSETS	
ITEM	Patient OR Guarantor	Spouse	Other	ITEM	Monthly Payment	Pmt Cur Y / N	ITEM	Balance / Value
Gross Income (Wages)				Mortgage / Rent			Checking Account	
Social Security or Disability				Utilities (electric, gas, water, trash, cable/satellite, etc)			Savings Account	
Unemployment Compensation				Cell Phone			Money Market, CD, IRA	
Workers Compensation				Groceries			Automobile	
Alimony and/or Child Support				Child Care			Automobile	
Public Assistance				Automobile Payment			Stocks / Bonds / Mutual Funds	
Rental Property				Insurance (Auto, Home, Health, Life, etc)			401K / 403B	
Pensions				Alimony / Child Support			Real Estate (Homestead)	
Dividends or Interest				Taxes (Personal property, Real Estate, etc)			Real Estate (0ther)	
Royalties (oil, gas, etc)				Medical			Other	
Other				Other			Other	
TOTAL				**TOTAL**			**TOTAL**	

GRAND TOTAL

PATIENT AGREEMENT

The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The original or a copy of this application will be retained by Peterson Regional Medical Center, even if financial assistance is not granted. The undersigned also agrees to allow Peterson Regional Medical Center to contact any or all of the above referenced for credit and asset verification, including credit bureaus.

____
Patient / Guarantor Signature Date

____
PRMC Representative Department

CERTIFICATIONS

I certify that I did not file a previous year's tax return for the following reason: ______________________ ______________________	I hereby certify that all information above is true and correct. There have been no changes to the original application or documentation: Pt/Guar Signature #1: Date: Pt Guar Signature #2: Date: Pt Guar Signature #3: Date:
Patient / Guarantor Signature Date	

PRMC USE ONLY: Certification Date/Initials #1: #2: #3: #4:

Thank you for choosing Peterson Regional Medical Center for your healthcare needs. In order to determine your eligibility for the in house financial assistance program please follow the instructions below.

1. Contact Hospital Solutions, Inc at (830) 258.7744 to be screened for possible assistance through County, State or Federal programs. You must be screened by Hospital Solutions, Inc. before you will be considered for the in house financial assistance program.
2. Complete the attached application in its entirety.
3. As proof of household income attach the following, as applicable:
    a. A copy of your ENTIRE Previous Years Income Tax Return, and all schedules (including but not limited to W-2, 1099, etc.)
    b. Copies of the last month's pay stubs for you and any employed members of your household, last 2 if paid biweekly and last 4 if paid weekly.
    c. Proof of Social Security and/or Disability income.
    d. Proof of Unemployment or Worker's compensation.
    e. Proof of Pension/Retirement payments.
    f. Proof of Child Support/Alimony payments.
    e. Proof of Dividends, Interest or Royalties payments.
    g. Proof of Public Assistance payments, to include food stamps.

PLEASE RETURN THE COMPLETED APPLICATION ALONG WITH ALL APPROPRIATE DOCUMENTATION. IF WE DO NOT RECEIVE THE COMPLETED APPLICATION AND ALL REQUIRED DOCUMENTATION YOUR REQUEST FOR ASSISTANCE WILL BE DENIED. NO FURTHER NOTICE WILL BE SENT AND OUR NORMAL COLLECTION PROCESS WILL RESUME.

If approved ONLY eligible bills with Peterson Regional Medical Center will be considered.

Please return the completed application in the envelope provided and/or call (830) 258-7527 to schedule a personal and confidential financial assistance appointment. Send application and all required documentation to:
BUSINESS OFFICE - FINANCIAL ASSISTANCE PROGRAM
551 Hill Country Drive
Kerrville, TX 78028