PETERSON HEALTH

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.
3. As proof of household income attach the following, as applicable:
    a. A copy of your entire previous year Income Tax Return, and all schedule (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 self employment income (i.e., monthly bank statements, letter from clients for cash pay)
    d. Proof of Social Security and/or Disability Income
    e. Proof of Unemployment or Worker's Compensation
    f. Proof of Pension/Retirement payments
    g. Proof of Child Support/Alimony payments
    h. Proof of Public Assistance payment, 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 COLLECTIONS PROCESS WILL RESUME.

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

Please return the completed application with all required documentation in the envelope provided to:

Peterson Health
BUSINESS OFFICE – FINANCIAL ASSISTANCE PROGRAM
551 Hill Country Drive
Kerrville, Tx 78028

For any further questions regarding this application please call our office at (830)258-7405.

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PETERSON HEALTH

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION

Patient Name	DOB	Medical Record #
Home Address City State Zip Code		
Social Security No.	Telephone No.	Marital Status
Name & Address of Employer		
Employer Telephone No.	Position / Title	How long employed?

RESPONSIBLE PARTY INFORMATION
(if application is for a minor child)

Responsible Party Name	DOB
Home Address City State Zip Code	
Social Security No.	Telephone No.	Marital Status
Name & Address of Employer		
Employer Telephone No.	Position / Title	How long employed?

SPOUSE INFORMATION
(for patient unless application is for a minor child, then enter spouse of Responsible Party)

Spouse Name	Spouse SSN	Spouse DOB
Name & Address of Employer		
Employer Telephone No.	Position / Title	How long employed?

DEPENDENT INFORMATION

Name & Date of Birth of all children living in the household (please use additional pages if more room needed)

Name	DOB	Name	DOB
Name	DOB	Name	DOB
Name	DOB	Name	DOB

ADDITIONAL QUESTIONNAIRES

Do you have Health Insurance? **Y / N** (if Yes, please provide insurance information:

Do you have a current SSI / SSDI case pending? **Y / N** (if yes, please provide date case filed:

PETERSON HEALTH

APPLICATION FOR FINANCIAL ASSISTANCE

MONTHLY INCOME				MONTHLY EXPENSES			ASSETS	
ITEM	Patient OR Resp Party	Spouse	Other	ITEM	Monthly Payment	Payment Current	ITEM	Balance / Value
Gross Income (Wages)				Mortgage / Rent		Y / N	Checking Account	
Social Security or Disability				Utilities (electric, gas, water, trash, cable/satellite, etc)		Y / N	Savings Account	
Unemployment Compensation				Cell Phone		Y / N	Money Market, CD, IRA	
Workers Compenation				Groceries		n/a	Automobile year/make/model	
Alimony and/or Child Support				Child Care		Y / N	Automobile year/make/model	
Public Asst. (ie: SNAP)				Car Payment		Y / N	Stocks / Bonds / Mutual Funds	
Rental Property				Insurance (Auto, Home, Health, Life, etc)		Y / N	401K / 403B	
Pensions				Alimony / Child Support		Y / N	Real Estate (Homestead)	
Royalities (oil, gas, etc)				Medical		Y / N	Other	
Other				Other		Y / N	Other	
TOTAL				**TOTAL**			**TOTAL**	

INCOME TAX CERTIFICATION

(to be completed if you did NOT file a tax return)

☐ I certify that I did not file a previous year's tax return for the following reason(s): _____

_____

_____ _____

Patient / Responsible Party Signature Date

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 / Responsible Party Signature Date