GUADALUPE COUNTY HOSPITAL

Financial Assistance Application

If you need help to complete this form, please ask to speak with Elena Tenorio or Christine Sanchez at 575-472-3417.

Patient Name: _____ Acct# _____

Responsible Party Name: _____ Date of Birth: _____

Address _____ City_____State _____ Zip _____

Home Phone _____Cell Phone _____

Instructions for completing this form:

This completed form should be attached to the required documentation and returned to GCH Patient Accounting to be processed.

- Prior year's tax return(s) or
- Minimum of two most recent pay stubs

Additional Household Members:

Name	DOB	Relationship	Source of Income	How Often? (Ex. weekly, bi-weekly, monthly)

Persons who apply for financial assistance are required to first explore other sources of funding. Please indicate which sources you have applied for and the reasons you are not eligible for this assistance.

Did the patient have Medical insurance at the time of service? Yes___ No_____ Medicare, If you answered **yes** to question 1 or 2
Did the patient have Medicaid at the time of service? Yes_____ No _____ please **attach a copy** of your insurance card.
Are you seeking GCH for a work related injury? Yes_____ No _____
Do you have any applications pending for Medicare or Medicaid? Yes_____ No _____
Are you currently approved for a discount at another hospital? Yes_____ No _____

If you reported $0 income, please provide a brief explanation of how you (or the patient) are surviving financially

_____

_____

_____

By my signature below, I certify that everything that I have stated on this application and on my attachment is true.

_____ _____

Applicant's signature Date

For Internal Use Only

Prepared by: _____ Date: _____

_____Approved Amount patient pays: _____0% _____25% _____ 50% _____100%

_____ Denied: _____income greater than 400% of federal poverty level _____ Documentation not received