Reeves County Hospital District
Hospital Charity Program
Application for Sliding Fee Discount Program
2323 Texas Street
Pecos TX 79772
(432) 447-3551

Name: _____

Address: _____

Cell Phone: _____

Household Size _____

Accounts # _____

To determine your eligibility we need the following additional information.

Para determinar su elegibilidad necesitamos la siguiente informacion

___ Texas Driver's License (or) Texas ID

___ Retirement Income

___ Statement on bank account

___ Statement on savings account

___ Paychecks stubs (One Current Month)

___ Most Recent Federal income tax return

___ Social Security Award Letter

___ Self Employment bookkeeping Sales, Expenditure records

___ Unemployment Compensation

____ Social Security Card (on person applying)

____ One Utility bill with current address

___ Letter of support

___ Child Support

Date: _____

FINANCIAL CREDIT SCREEN

MONTHLY INCOME

Employer: _____

Spouse's Employer: _____

Monthly GROSS pay: $_____

Spouse's GROSS Pay: $_____

Social Security: $_____

Welfare: $_____

Aid to Dependent Children: $_____

Interest/Dividends: $_____

Rental Income: $_____

Retirement Income: $_____

Veteran's Benefits: $_____

Other: $_____

TOTOAL MONTHLY INCOME: $_____

ANNUAL ADJUSTED GROSS INCOME

(Most Recent Return) $_____

* **ASSETS**

Bank Accounts:

Checking $_____

Savings $_____

Home: Assessed Value: $_____

Equity: $_____

Stocks and Bonds: $_____

Auto: Year _____

Make _____

MONTHLY EXPENSES

Rent/Mortgage Payment $_____

Food and Misc $_____

Utilities:

Telephone $_____

Gas $_____

Electricity $_____

Water $_____

Taxes: $_____

Transportation: $_____

Automobile Payment $_____

Gasoline $_____

Medical Expenses:

Doctor: $_____

Hospital: $_____

Patient's Medications: $_____

Medications for Family: $_____

Insurance:

Medical $_____

Life $_____

Automobile $_____

Charge Accounts:

Loans $_____

Others $_____

TOTAL MONTHLY EXPENSES $_____

LIABILITIES

Loans Payable to Banks $_____

Loans Payable to Others $_____

Other Debts $_____

The applicant agrees that any financial assistance granted shall be applied to bills and/or deductibles. In submitting this application the patient guarantees its accuracy and truth with the intent that it be relied upon by Reeves County Hospital District in considering assistance to the undersigned. (Documentation may be required).

Patient's Signature: _____ Date: _____

Percent pays $_____%of charges Patient pays $_____ Deductible Patient pays $_____ Deposit

Evaluation Date: _____ Evaluated by: _____

***The assets information is optional and is not used to determine SFS eligibility.**

Reeves County Hospital District Hospital Charity

Date: _____

Approved Til _____

Bomi Bharucha- Chief Financial Officer

Reeves County Hospital District

Patient: _____

Address: _____

Date of Birth: _____

Family Size: _____

Place of Employment: _____

Source of Income: _____

Indigent Status: _____

Amount of Debt/S_____

Reason for Proposal:

Medical Charity: _____

Explain: _____

_____

_____

Thank You,

Rose Cobos —Collector

432-447-3551 EXT# 2349

Approved_____ Disapproved_____

Bomi Bharucha—CFO_____ Date: _____

2323 Texas Street

Pecos, Texas 79772

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WebSite: reevescountyhospital.com