FINANCIAL INFORMATION FORM / FINANCIAL ASSISTANCE APPLICATION

Patient Name:	**Phone:**
Patient Street Address:	**City, State, Zip Code:**
Account Number(s):	**Date(s) of Service:**

INSTRUCTIONS: **All questions must be answered. If a question does not pertain, write N/A on the line.**
Attach a photocopy of <u>one</u> proof of identity with a picture (example: state-issued driver license or Passport with picture, etc.) *
Attach a photocopy of the most recent Income Tax return *or*
Attach a photocopy of <u>one</u> of the following proofs of income:

** If photo ID is not available, other documents showing identity may be used. Contact phone number above for assistance.*

- ☐ Last 2 paycheck stubs
- ☐ Unemployment benefit confirmation slip
- ☐ Social Security check or award letter
- ☐ Letter from employer stating employee name, occupation, hourly wage, number of hours worked

****** This is not considered a complete application without the supporting documentation. ******

STATUS: ☐ Permanent Texas Resident ☐ Legal Resident ☐ Immigrant Visa ☐ Non-Immigrant Visa

MARITAL STATUS (check one): ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

CHILDREN UNDER 18 YEARS OLD AND OTHER DEPENDENTS WITHIN THE HOUSEHOLD (Continue on another page, if needed)

Full Name	Date of Birth	Relationship of Dependents (check one)				
		Child	Step-Child	Guardian	Adult/Senior	Not Related

EMPLOYMENT SUMMARY

Patient	Spouse
Employer	Employer
Occupation	Occupation
Employment Status (check one) ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Housewife ☐ Unable to return to work	*Employment Status (check one)* ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Housewife ☐ Unable to return to work

HOUSEHOLD INCOME PER MONTH

Patient	$	/mo.
Spouse	$	/mo.
Alimony	$	/mo.
Unemployment	$	/mo.
Child Support	$	/mo.
Survivors Benefit	$	/mo.
Workers Comp	$	/mo.
Trust Fund	$	/mo.
Other	$	/mo.
TOTAL INCOME	$	/mo.

HOUSEHOLD EXPENSES PER MONTH (Not applicable for FAA)

Housing:	____ Own/Loan	____ Rent
House Payment	$	/mo.
Utilities (electric, water)	$	/mo.
Car # 1	$	/mo.
Car # 2	$	/mo.
Gasoline	$	/mo.
Insurance	$	/mo.
TV/ Cable / Phone	$	/mo.
Food	$	/mo.
TOTAL EXPENSES	$	/mo.

BANK ACCOUNTS/OTHER ASSETS (must answer all 3 questions): **(Not applicable for FAA)**

Checking Account? (circle one)	Yes	No	Current Balance	$
Savings Account? (circle one)	Yes	No	Current Balance	$
Additional Property? (circle one)	Yes	No	Current Value	$
	If Yes, please describe:			

INTRACARE NORTH HOSPITAL

Patient Name: _____

1. I attest under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
2. The information I provided reflects HOUSEHOLD income and expenses.
3. This information as well as a credit report and other publicly available information may be used by Intracare North Hospital to establish a payment plan and/or to initiate an application for financial assistance and/or to determine eligibility for various program, coverage and assistance.
4. I give my consent to Intracare North Hospital to obtain information from any source to verify the statements I have made.
5. You will receive written communication from Intracare North Hospital if the information provided is incomplete or insufficient to determine your eligibility for financial assistance or if you do not meet the eligibility qualifications. You will also be notified in writing if you are eligible for financial assistance.
6. Patients who apply for financial assistance may be eligible for funds from local, state, or federal programs. Patients are expected to apply for such programs before a determination of eligibility for financial assistance. Intracare North Hospital will advise to individuals in applying such programs. Failure to apply such programs may adversely affect consideration of the patient's Financial Assistance application.
7. I attest to the fact that I have applied for all possible insurance coverage, including Medicaid, Crime Victims, Health Exchange Insurance and any other local, state or federal coverage.
8. I understand that if I do not qualify for financial assistance, I will be responsible for the cost of the psychiatric necessary health care that ICN provided to you.
9. If you need assistance in completing the form, please call ICN business office financial counselor at 281-893-7200 x3121 .

_____ _____

Patient/ Guarantor Signature Date

_____ _____

Patient/ Guarantor Printed Name Date

Please mail or fax your completed application and ALL supporting documents to:Intracare North Hospital, Attn: Business Office Financial Counselor,1120 Cypress Station Drive, Houston, TX 77090.

Financial Assistance Approved or Denied by ICN CEO, CFO and/or BO Director (Circle one)

_____ _____

Name / Signature Title Date