Financial Summary

Information and Instruction Sheet

How do I apply for Assistance?

You can apply for assistance by filling out a Financial Summary.

What do I do with the Financial Summary after filling out all the information?

You can:

1) Mail to Driscoll Children's Hospital,
   Attn: Admitting Office 1st Floor
   P.O. Box 6530
   Corpus Christi, Texas 78466
   or
2) Or you may drop it off at the Admitting Office located on the first floor of the hospital behind the gift shop any day between 7:00 a.m. to 8:00 p.m.

Do I need to provide any information with my application?

Yes. Provide a copy of a valid ID or a Texas Drives License, validation of income by any documentation listed below.

1	IRS Form W-2	8	Employer Verification
2	Paycheck Remittance	9	Bank Statement
3	Tax Return	10	Written Attestation
4	Social Security	13	Other
5	Workers' Comp		
6	Unemployed Comp Letter		
7	Federal Income Government Program		

When will I know if I will receive assistance with my hospital bill?

You may contact us at (361) 694-4758.

Will Financial Assistance pay the Doctor's and any other bills for this visit?

No. Driscoll Children's Hospital Financial Assistance will not pay for Doctor Bills, X-ray interpretations, and Ancillary Service. Any prescriptions or services not received at Driscoll Children's Hospital will not be covered.

If I do not receive notice and I need to bring my child to Driscoll will my child be seen?

Yes. Your child will be seen. While at the hospital you may speak with a financial counselor in the Admitting Office or the ED discharge desk to inquire about the status of your application.

Financial Summary

APPLICANT'S INFORMATION:

Name: _____ Sex □Male □Female
Last First Middle
Relationship to Patient?: □ Patient □ Father □Mother □Guardian

Telephone #: (_____) _____ - _____

Who is legally responsible for the medical care of the ☐ Fathe ☐ Mother ☐ Both □ Guardian: _____

MEMBERS OF HOUSEHOLD:

Name	Date of Birth	Relationship to	Social Security

PATIENT INFORMATION:

Name: _____ ☐ male ☐ female
Last First Middle
Social Security#: _____ - _____ - _____ Date of Birth: month _____ day _____ year _____

Place of Birth: City/State County: _____
Are you a legal resident of Texas?: □No □Yes If no?: □ Visiting visa □ On a student visa □ Permission to work
Is the Patient Insured? □ No □Yes – Please provide copy of insurance card
If yes, through whom: □Both Parents □Mother □Father □Patient □Other
If other, please provide the name and relationship to the patient:

PATIENT'S PARENT/GUARDIAN INFORMATION:

FATHER'S FULL NAME

Last First Middle

Social Security Number:----------

Date of Birth: Mo.-------- Day---------- Year--------

Telephone #: (_____) _____-_____

□Living
□Deceased
□Married
□Single
□Separated
□Divorced
□Widowed

Are you a legal resident of Texas? □Yes □No
Address if different from patient's:
Street----------
City:----------
State: _____ Zip Code: _____

Business Phone #: (_____) _____ - _____

Occupation: _____

Employer Name: _____ Length of Employment: _____

Emp. Address: _____ City: _____ Zip: _____ Phone#: _____

Gross Income: $_____ per pay period. $ ___per hour Number of hours worked per week: ____

□ Salary – exempt □ Non Salary – nonexempt Paid? □ Weekly □Bi-weekly □Monthly □ Yearly

Financial Summary

MOTHER'S FULL NAME

Last First Middle

Social Security ----------

Date of Birth: Mo.--------- Day---------- Year--------

Telephone #: (_____) _____-_____

□Living □Deceased □Married □Single □Separated □Divorced □Widowed

Are you a legal resident of Texas? □Yes □No

Address if different from patient's:

Street----------

City:----------

State: _____ Zip Code: _____

Business Phone #: (_____) _____ - _____

Occupation: _____

Employer Name: _____ Length of Employment: _____

Emp. Address: _____ City: _____ Zip: _____ Phone#: _____

Gross Income: $_____ per pay period. $ ___per hour Number of hours worked per week: ____

□ Salary – exempt □ Non Salary – nonexempt Paid? □ Weekly □Bi-weekly □Monthly □ Yearly

GUARDIAN'S FULL NAME

Last First Middle

Social Security ----------

Date of Birth: Mo.--------- Day---------- Year--------

Telephone #: (_____) _____-_____

□Living □Deceased □Married □Single □Separated □Divorced □Widowed

Are you a legal resident of Texas? □Yes □No

Address if different from patient's:

Street----------

City:----------

State: _____ Zip Code: _____

Business Phone #: (_____) _____ - _____

Occupation: _____

Employer Name: _____ Length of Employment: _____

Emp. Address: _____ City: _____ Zip: _____ Phone#: _____

Gross Income: $_____ per pay period. $ ___per hour Number of hours worked per week: ____

□ Salary – exempt □ Non Salary – nonexempt Paid? □ Weekly □Bi-weekly □Monthly □ Yearly

MEDICAID AND OTHER BENEFITS:

Does Medicaid cover patient? □No □Yes If yes, patient's Medicaid #?: _____ Mother's Medicaid #?: _____

Does Medicare cover patient? □No □Yes If yes, Medicare #?: _____

Check other benefits being received: □Food Stamps Amount$: _____ □WIC □Other: _____

Is the patient or other household members receiving benefits from other programs, fund raising activities, special charities, gifts, and / or donations?: □No □Yes If yes, please list:

1. _____ Amt$: _____
2. _____ Amt$: _____

Financial Summary

OTHER INCOME RESOURCES: Check Yes or No on each item and enter the amount if the response is yes

Type	No	Yes	If Yes, $ Received / per month	Type	No	Yes	If Yes, $ Received / per month
Child Support				Unemployment Comp			
Social Security				Rental Property			
Social Security Disability/SSI				Disability Income			
Social Security Survivors Benefit				TANF			
Workman's Compensation				Other			

LIVING ARRANGEMENTS: (check one)

□ Own/buying home □ Renting □Live with Friends / Relatives □No permanent

Address MONTHLY EXPENSES:

Expenses	Payment	Amount Owned	Expenses	Payment	Amount Owed
Housing			**Sitters**		
Utilities			**Autos**		
Food			**Auto Insurance**		
Creditors			**Total**		

VALUE OF ASSETS:

1	**Do you own other real estate (not including your home)?**	**□No**	**□Yes**	**If yes, current value?**	**$**
2	**Do you own a farm?**	**□No**	**□Yes**	**If yes, current market value?**	**$**
3	**Checking Account?**	**□No**	**□Yes**	**If yes, name of bank?**	
4	**Savings Account?**	**□No**	**□Yes**	**If yes, name of bank?**	
5	**Cash value life insurance?**	**□No**	**□Yes**	**If yes, name of Insurance**	
6	**Automobiles? □No □Yes**	**Make**	**Model**	**Year**	**Amount Owed**
7	**If yes, please list Make/Model/Year/Amount Owed>>>**				
8	**If yes, please list Make/Model/Year/Amount Owed>>>**				

Estimate the amount of medical bills in the **PAST THREE MONTHS**: $_____

WHO CAN WE CONTACT IF WE NEED TO REACH YOU?

Name: _____ Phone#: _____

CERTIFICATION & RELEASE OF INFORMATION

I hereby certify that the above information is correct. I also give Driscoll Children's Hospital my permission to release any medical or financial information, which may enable the hospital to find some assistance in paying my child's hospital charges.

Signature of Parent/Guardian: X _____ Date: _____

X _____ Date: _____

For Office Use Only: Evaluator Name: Qualified? □No □Yes _____%