El Paso Children's Hospital
Financial Assistance Application
4845 Alameda Avenue
El Paso, Texas 79905
Phone (915)298-5444 Ext. 43109 or Ext. 43106

____
Patient Name Patient Account Number

____
Telephone Number Social Security Number Birth Date (Month/Date/Year)

____
☐ Employed Employer (Name, Address and Telephone Number)
☐ Unemployed

____
Spouse Name Social Security Number Birth Date (Month/Date/Year)

A. *Income:* Please provide the income for each of the following persons in your household.

		Circle One			**Circle One**
Patient	$______________	/Hr /Wk /Month /Year	Patient's Father (if patient is a minor)	$_____________	/Hr /Wk /Month /Year
Spouse	$______________	/Hr /Wk /Month /Year	Patient's Mother (if patient is a minor)	$_____________	/Hr /Wk /Month /Year

Total Yearly Family Income: $_______________

B. *Family Members:* Please provide the number of persons in the patient's household. ___________________

C. *Income Verification:* Please provide the following types of documentation to verify your income.

- IRS Form W-2
- Paycheck Remittance
- Tax Return
- Bank Statements
- Employer Verification
- Proof of Participation in TANF
- Unemployment Compensation Determination Letters
- Proof of Participation in a Government Assistance Program other than TANF, such as CIDC, Medicaid or food stamps
- Social Security or Workers' Compensation Determination Letters
- RSDI letter

- Other, Please Describe:
____
____
____
- If you are unable to provide one of the sources of income documentation listed in Section C, please explain why this information is not available:
____
____
____
____

D. *Residency*:

Give your household's county and state of residence (where you make your permanent home) or where you intend to reside if you do not have a permanent home:

County: ________________ State: __________________

Please check all of the following that apply to you.

_____ Minor student whose parents primarily support you and who live outside of El Paso County
_____ Inmate or resident of a institution operated by a state or federal agency
_____ Inmate or resident of a state school
_____ Moved to El Paso County solely to obtain healthcare assistance

Proof of residency or intent to reside includes two of the following: mail addressed to you, your spouse or children; voting records; automobile registration; driver's license or other official identification; school enrollment records; property tax receipts; or rent, mortgage payment, and utility receipts.

I understand that El Paso Children's Hospital may verify the financial information contained in this Financial Assistance Application ("Application") in connection with UMC-El Paso's evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize El Paso Children's to request reports from credit reporting agencies and the Social Security Administration. I am aware that falsification of information on this Application may result in denial of entitlement to financial assistance.

____Date__________________________
Signature of Patient or Responsible Party

____Date__________________________
Hospital Associate Signature if any part of Financial Assistance Application Completed by a Hospital Associate