Form A

COOK CHILDREN'S NORTHEAST HOSPITAL

FINANCIAL ASSISTANCE FORM

FORM MUST BE COMPLETED, SIGNED AND RETURNED BY: _____
Please print neatly. Answer every question. (Write "N/A "if the question does not apply)

ACCOUNT # OR PATIENT NAME: _____

GUARANTOR NAME: _____HOME PHONE:_____CELL PHONE:_____

EMPLOYER: _____WORK PHONE:_____

SPOUSE'S NAME:_____

EMPLOYER: _____WORK PHONE:_____

GUARANTOR ADDRESS: _____

CITY: _____STATE:_____ ZIP CODE: _____

DISCLOSURE: BEFORE APPLYING FOR FINANCIAL ASSISTANCE WITH COOK CHILDREN'S NORTHEAST HOSPITAL YOU MUST SHOW PROOF OF APPLICATION AND/OR DENIAL FROM MEDICAID, CSHCN, CHIP OR ANY OTHER STATE PROGRAM FOR WHICH YOUR CHILD MIGHT BE ELIGIBLE OR PROVIDE INCOME DOCUMENTATION THAT INDICATES ELIGIBILITY IS NOT POSSIBLE. FAILURE TO DO SO WILL RESULT IN AUTOMATIC DISQUALIFICATION.

Cook Children's Northeast Hospital may require an applicant for financial assistance to furnish any information that is reasonably necessary to substantiate the applicant's eligibility. Failure to do so within the above stated time frame will result in denial of eligibility, and the entire bill will be due and payable immediately. I also understand that if the information I submit is false, the request will be denied and any prior determination to eligibility for uncompensated services will be retroactively revoked and I will be responsible for payment of all charges.

I certify that the information contained in the application is true, correct and complete. I understand that, should this request for financial assistance be denied for any reason, I will be fully responsible for financial obligations arising from health care services. I further understand that should I receive partial assistance I will be fully responsible for the remaining balance.

_____ _____

Signature Date

Mailing address:

6316 Precinct Line Rd.
Hurst, Texas 76054

Attn: Business Office
Phone: 817-605-2500

Form A (continued)

LAST FIRST RELATIONSHIP AGE GROSS INCOME

1._____

2._____

3._____

4._____

TOTAL NUMBERS OF HOUSEHOLD MEMBERS: _____

ATTACH A COPY OF ONE OF THE FOLLOWING AS VERIFIABLE PROOF OF INCOME:

- **W-2**
- **PRIOR YEAR'S TAX RETURN**
- **PAY CHECK STUBS**
- **RETIREMENT CHECKS STUBS**
- **SOCIAL SECURITY LETTERS OR DEPOSIT SLIPS SHOWING THE AMOUNT OF THE SOCIAL SECURITY DEPOSITS**
- **UNEMPLOYMENT CHECK STUBS**
- **OTHER GOVERNMENT PROGRAM CHECK STUBS**
- **LETTER FROM EMPLOYER, ON EMPLOYER LETTERHEAD, INDICATING THE PAYMENT AMOUNT**

INCOME INFORMATION:

Monthly Income: Wages $_____
Public Assistance $_____
Social Security $ _____
Unemployment Compensation $ _____
Alimony $_____
Child Support $_____
Pension $_____
Dividends, interest $_____
Income from
Rent, real estate $ _____
Other income (describe)
_____ $_____

TOTAL INCOME $_____