El Paso County Hospital District
Financial Assistance Application

Patient Name _____ Patient Account Number _____

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

☐ Employed
☐ Unemployed

Employer (Name, Address and Telephone Number) _____

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 University Medical Center of El Paso may verify the financial information contained in this Financial Assistance Application ("Application") in connection with University Medical Center of 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 University Medical Center of El Paso 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 Employee