



City Hospital at White Rock
Financial Assistance Application

Patient Account Number

RETURN TO: City Hospital
9440 Poppy Drive
Dallas, Tx 75218
Attn: Financial Asst Dept

Patient Name (Last, First, MI) Social Security Number

Patient Address City State Zip Code

Birth Date (Month/Date/Year) Telephone Number Marital Status: Married Single Widowed

Employed: Yes No Spouse's Name: Employed: Yes No

Patient's Spouse's

Employer Employer

Telephone # Telephone#

Other City Hospital at White Rock accounts for your household with an unpaid balance (Please list patient's NAME, DOB and FACILITY NAME)
\*\*If unemployed, please include the previous employer's name and telephone number\*\*

A. Income: Please provide the income for each of the following persons in your household.
Patient Full Time Part Time - Hours/Week = \$ HR Wk Bi-Wk Month Year
Spouse Full Time Part Time - Hours/Week = \$ HR Wk Bi-Wk Month Year
Total Household Income \$
Please complete only if patient is a minor (if not leave blank)
Patient's Father Full Time Part Time - Hours/Week = \$ HR Wk Bi-Wk Month Year
Patient's Mother Full Time Part Time - Hours/Week = \$ HR Wk Bi-Wk Month Year
Total Household Income \$

B. Income Verification: Please provide verification (send only copies, no original documentation) for all sources of household income (acceptable documentation listed below). Check attached documents:
Pay Check Remittance Employer Verification Credit Inquiry (completed by CHWR)
IRS Form W-2 Tax Return Governmental Assistance (food stamps, CDIC, Medicaid, TANF)
Bank Statement Other (describe below) Social Security, Workers Compensation or Unemployment Compensation Determination Letters
If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

C. Family Members: Please provide the total number of people in the patient's household. (This number should only include the patient, patient's spouse, and the patient's dependents)

D. Assets and Other Resources:
Do you have any assets or other resources available to you? Yes No If Yes, current amount available: \$
Do you have medical insurance? Yes No If Yes, please list provider name:
Do you have a Health Savings Account or Flexible Spending Account? Yes No If Yes, current amount available: \$

I understand City Hospital at White Rock ("CHWR") may verify the financial information contained in this Financial Assistance Application ("Application") in connection with CHWR's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize CHWR to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance. I further understand that some physicians and providers may not be employees of CHWR. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

Signature of Patient or Responsible Party Printed Name Date

For Hospital Use Only
Application information obtained by CHWR Employee in person or over The phone, no patient signature required. Electronic Signature of CHWR Employee or CHWR Representative Date
Notes Regarding Income Verification/Number in the Household:
Patient is part of community care program Program Name: