Tyler County Hospital
We may be small, but we care big!

P O BOX 549
WOODVILLE, TEXAS 75979

Telephone 409.283.6498
Facsimile 409.283.6430

Date:

Dear Patient/Client:

Please find attached a Medical Assistance Application for your convenience. Please complete the application and return it with all required documentation within five business days. This program is based on family size and income. The requested information is for all household members.

Patient Identification can be shown by **2** of the following : Social Security Card, Drivers License, Voter Registration Card, Credit Card, Employee Identification, Birth Certificate, Baptismal Record, School Transcript, Marriage License, or Medicare/Medicaid Card.

Proof of Income must include the following: Wages and Salaries before deductions, Self-Employed Income, Farm Income, Public Assistance, Unemployment Benefits, Worker's Compensation, Strike Benefits, Veterans Benefits, Child Support, Pensions, Annuities, Income from Dividends, Interest Income, Rental Income, Royalties, or Income from Estate and Trusts.

Proof of Dependency can be shown by any of the following: Current Income Tax Form 1040 or 1040A listing, School Records, Birth Records, Hospital Records, Baptismal Records, Proof of Guardianship or AFDC Records.

Proof of Residency can be shown by any of the following: Rent Receipts, Utility Bills, Voter Registration Card or Food Stamp Eligibility Letters.

When documentation is received, all applications will be processed and notification sent by mail.
Approval for the program is good for a period of 1 year, and all balances which remain after the discount are monitored according to Tyler County Hospital's collection policy.
If you do not wish to take advantage of our Medical Assistance Program, our collection policy is still in effect, all accounts paid in full. If you have any questions or concerns about our Charity Care Program, please call 409-283-6498.

Sincerely,

Velissa Bell
Financial Department

* Your application cannot be processed without ALL requested information.
Form 1- Cover Letter

Note: Your application **will not** be processed unless all required documentation is included.

MEDICAL ASSESSMENT
(Charity Care Services)
TYLER COUNTY HOSPITAL DISTRICT

PERSONAL INFORMATION

Applicant's Name:_____Soc. Sec.#_____

Address:_____ City:_____

State_____Zip:_____Date of Birth:_____

Telephone #:_____ How long at this address:_____

Mortgage Holder/LandLord:_____Telephone #: _____

Previous Address: _____

Place of Employment: _____How long?: _____

CO-APPLICANT INFORMATION:

Co-applicant's Name:_____Soc. Sec.#_____

Address: _____City: _____

State: _____Zip: _____Date of Birth: _____

Telephone #: _____How long at this address: _____

Previous Address: _____

Place of Employment: _____How Long?: _____

DEPENDENT INFORMATION:

Number of dependants living in household: _____ Adults _____ Children _____

Children's Age: _____ _____ _____ _____ _____ _____

Are all children in household the mutual children of husband and wife? ____Yes ____ No

If no, explain:_____

_____

ASSETS:

Total Monthly Income:_____ Name of Banking Institution_____

Checking Acct. Bal.:_____ Savings Acct. Bal.:_____ C.D.(s) Bal.:_____

Automobile(s): Year:_____ Make:_____ Model:_____

Year:_____ Make:_____ Model:_____

List other Assets: (boats, campers, rental properties, stocks, bonds, trust funds, tractors & ¾ wheelers- all other resources)_____
_____
_____

Please list below person(s) you are responsible for. Please include date of birth and social security number(s) for each dependent. Use additional sheet if necessary to include all dependents.

Name	**Date of Birth**	**Social Security Number**

I certify that the information provided in the application is true and correct to the best of my knowledge. By signing below I authorize Tyler County Hospital District of Woodville, Texas to check my credit and any employment history. I understand that I must update credit information as changes occur.

_____ _____

Applicant's Signature Date Co-Applicant's Signature Date

FOR HOSPITAL USE ONLY:

Assessment Date: _____

Medical or Financial is: ☐ Approved ☐ Denied
Reason: _____

_____

Sliding Scale Discount Percent: _____%

Amount of discount: $_____ Remaining Balance Due:$_____

_____

SCOTT MCCLUSKEY CFO Date