Financial Assistance Application

Form content not retained in medical record.
For local storage only.

complete fields or place patient label here

Patient Name *(First, Middle, Last)*	
Birth Date *(mm-dd-yyyy)*	Room Number *(if applicable)*
CapRock Hospital Account Number:	

Applicant Name *(First, Middle, Last)*

Instructions: Complete application and attach copies of:

- Tax returns and supporting schedules (previous 2 years)
- Social Security benefits (if applicable)
- On a separate page describe your need for financial assistance
- Pay stubs (most recent 3 months)
- Bank statements (most recent 3 months for all accounts)
- W-2 or Unemployment statements

I have applied for or will apply for federal or state medical assistance or have verified my health care exchange plan eligibility.
Yes No Reason

I have a lawsuit, settlement, personal injury, or liability claim pending.
Yes No Reason

I have the availability of insurance through my employer or my spouse's employer.
Yes No Reason

Household Annual Income (as reported on income tax filing)	Household Size (patient, spouse, and dependents as reported on income tax filing)

Patient or Responsible Party

Name *(First, Middle, Last)*		Birth Date *(mm-dd-yyyy)*

Address:	City:	State:	Zip Code:

Phone:	Marital Status:

Employment Status: Full Time / Part Time / Self Employed / Unemployed / Student

Employer Name:

Employment Length:	Unemployed Date/Length *(mm-dd-yyyy)*	Are you claimed on another tax return? Yes / No — If "Yes", provide tax returns (previous 2 years)

Spouse or Partner (Used to identify all patient accounts eligible for financial assistance)

Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*

Employment Status: Full Time / Part Time / Self Employed / Unemployed / Student

Employer Name:

Employment Length:	Unemployed Date/Length *(mm-dd-yyyy)*

Dependents (If more than 4 dependents use separate page)

Full Name:	Relationship:	Birth Date:
1		
2		
3		
4		

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(Continued)

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Patient Name *(First, Middle, Last)*	
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CapRock Hospital Account Number:	

Other Income

Description	Monthly Income Amount

Medical Debt

Type	To Whom	Unpaid Balance	Monthly Payment
Medical Doctor			
Medical Hospital			
Other			

Certification Signatures

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by CapRock Hospital or an affiliated entity and I give permission to CapRock Hospital and all affiliated entities to share the information as necessary to consider my financial assistance request. I hereby grant permission to CapRock Hospital, all CapRock Hospital affiliates and representatives or agents to investigate the information contained herein.

Patient or Responsible Party Signature *(signature required)*	Date Today *(mm, dd, yyyy)*

Patient or Responsible Party Printed Name *(First, Middle, Last)*

Spouse or Partner Signature *(signature required)*	Date Today *(mm, dd, yyyy)*

Spouse or Partner Printed Name *(First, Middle, Last)*