

PECOS COUNTY HEALTH SYSTEM

CHARITY CARE
QUESTIONNAIRE

Applicant's Name _____ Relationship to Patient _____

Name of Patient _____ DOB _____ Marital Status _____

Address _____ Phone# _____

Previous Address _____

Spouse's Name _____ Spouse's DOB _____

Your Social Security Number _____

Spouse's Social Security Number _____

	Yes	No
Do you have medical insurance?	_____	_____
Have you applied for Indigent Care with the County?	_____	_____
Were you denied Indigent Care from the County?	_____	_____
Have you applied for Medicaid?	_____	_____
Were you denied access to Medicaid benefits?	_____	_____
Have you applied for benefits with the Social Security Administration?	_____	_____
Were you denied benefits by the Social Security Administration?	_____	_____
Have you applied for Supplemental Security Income?	_____	_____
Were you denied Supplemental Security Income benefits?	_____	_____

Assets

Home: () Rent () Buy () Own Monthly payment \$ _____

Auto: _____ Year _____ Make _____ Model _____ Monthly payment \$ _____

Provide copies of all medical bills in or out of Pecos County Total Amount \$ _____

**PECOS COUNTY HEALTH SYSTEM
CHARITY CARE FORMULA**

Patient Name: _____

Applicant Name: _____

- | | | |
|-----|--|-----------------------|
| 1. | Gross Family Income (from IRS 1040 or W-2): | _____ |
| 2. | Other income:
(If tax form unavailable detail income
Items. I.E. Child Support, Rental Income, Babysitting,
And any in-home business) | _____ |
| 3. | _____ : | + _____ |
| 4. | _____ : | + _____ |
| 5. | _____ : | + _____ |
| 6. | _____ : | + _____ |
| 7. | _____ : | + _____ |
| 8. | House payment or Rent (annual): | - _____ |
| 9. | Car payment (not to exceed \$200/mo.): | - _____ |
| 10. | 75% of Savings Account Balance: | + _____ |
| 11. | CD Balance: | + _____ |
| 12. | Other Liquid Assets: (i.e. Cash Value of Life Insurance) | + _____ |
| 13. | Available Resources: | SUM

_____ |
| 14. | Total Medical Bills for Past Two Years: | _____
_____ |
| 15. | Percent Available Resources:
((Line 14/Line 13) x 100) | _____ |
| 16. | Any Applicant scoring above 15% will be
Considered for Charity Care. | |

APPROVED: _____ DISAPPROVED: _____

JUSTIFICATION _____

PECOS COUNTY HEALTH SYSTEM

CHARITY CARE AGREEMENT

I swear that the information that I have provided in application for assistance through the Charity Care Program is true and correct to the best of my knowledge.

SIGNED _____