Texas Children's	**Financial Assessment and Charity Care Policy and Procedure**	
Policy # 3085	***Categories*** Administration / Non-Clinical Patient Financial Services, Revenue Cycle	***This Policy Applies To:*** Texas Children's Hospital, Texas Children's Physician Services Organization, Texas Children's Women's Specialists
		Document Owner Enrique Gonzalez

GENERAL POLICY

Texas Children's Hospital, Texas Children's Physician Services Organization, and Texas Children's Women's Specialists (collectively referred to herein as "TCH") are committed to providing the highest quality care to its patients. TCH recognizes that some patients and/or their families may be unable to pay for all or a portion of the services provided by TCH and its substantially related entities. In furtherance of its charitable mission and values, TCH provides financial assistance to patients and/or their families who are low-income, uninsured or underinsured, ineligible for government health care programs, and who are otherwise unable to pay some or all of the bills related to services deemed "medically necessary" by Medicare, Medicaid, or industry standards. Financial assistance also may be available to other patients, and for other services, determined on a case-by-case basis in accordance with the procedures set forth herein.

No patient will be denied financial assistance because of gender, race, creed, color, national identity/ethnic origin, religion, age, sexual orientation or disability. In addition, TCH will provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for financial assistance.

DEFINITIONS

Bad Debt: Any balance due amount submitted for payment by the guarantor that has not paid in full and unlikely to be paid for various reasons resulting in an uncompensated care write-off.

Family Income or Gross Income: Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance payments, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Family Income is based on definitions used by U.S. Bureau of the Census.

Federal Poverty Level ("FPL"): A measure defined by the United States Department of Health and Human Services based on Gross Income and household size to indicate poverty threshold.

Financial Assistance: A full or partial reduction in charges incurred at TCH and its substantially related entities to patients for emergency or medically necessary services who

have qualified for a discounted rate in accordance with the provisions of this Financial Assistance Policy. An Uninsured Self-Pay Patient or Under-insured Patient for the relevant service who is not eligible for coverage through a Government Healthcare Program or other insurance, and who has Family Income less than or equal to 400% of FPL, may be eligible to receive Financial Assistance in the form of discounted charges.

Financial Assistance Committee: A committee of TCH comprised of appropriate representatives from TCH and/or Medical Staff with responsibility for: 1) monthly review and approval of applications for Financial Assistance which fall outside the guidelines set up in the Charity Standard Operating Procedure and 2) monthly review of financial reports associated with Financial Assistance at TCH.

Financial Assistance Deductible: The portion of a TCH bill that is the patient's responsibility once approved for Financial Assistance. This amount may be determined by the Financial Assistance Committee, as exceptions to the sliding scale as set forth in this Charity Operating Procedure.

Financially Indigent: A patient who TCH has determined to be unable to pay some or all of the patient's bills due to the Family Income of the patient and/or the patient's family being below specified thresholds based on the FPL and/or because their monetary assets are below specified thresholds.

Government Healthcare Program: Any healthcare program operated or financed at least in part by the federal, state or local government, including but not limited to, Medicare, Medicaid, Children with Special Health Care Needs ("CSHCN"), and Children's Health Insurance Program ("CHIP").

Gross Charges: Charges that are billed to individuals receiving services at TCH.

Medically Indigent: A patient who TCH has determined to be unable to pay some or all of the patient's bills related to services deemed medically necessary by Medicare, Medicaid and Insurance industry standards, because such bills exceed a certain percentage of the Family Income and/or assets of the patient and/or the patient's family (e.g., due to catastrophic cost or other conditions), even though the patient and/or the patient's family have Family Income or assets that disqualify them from being Financially Indigent.

Presumptive Eligibility: A patient who has not submitted a completed application for Financial Assistance, but whose circumstances fit within one or more of the following criteria

Homeless;

Enrolled or Eligible for Medicaid or CSHCN, but not on the date of service or for a non-covered service;

Enrolled in governmental programs for low-income individuals and program funds are not available (i.e. budget shortfall);

Referred for services by the Harris County Health System having eligibility criteria; and

Identified utilizing third party software, such as propensity to pay/financial assistance eligibility/enrollment as having eligibility criteria in accordance with this Financial Assistance Policy.

Under-insured Patient: A patient who has some insurance or third-party coverage but has out-of-pocket expenses (e.g. self-pay balances associated with high deductible/out of pocket or limited benefit plans) that exceed the patient's ability to pay and fall within the financial assistance sliding scale.

Uninsured Self-Pay Patient: A patient who has no insurance or third-party coverage to assist with meeting the patient's payment obligations.

PROCEDURE

1. OVERVIEW

1.1. The TCH Patient Financial Services Department, which includes Patient Access and Customer Service, will identify patients who may be eligible for Financial Assistance.

1.2. A patient may also request Financial Assistance if not identified by the Patient Financial Services Department. A patient requesting Financial Assistance will be referred to a Financial Counselor or Patient Services Specialist for guidance on the Financial Assistance process.

1.3. A patient seeking Financial Assistance may be asked to complete an application with a Financial Counselor or Patient Services Specialist. However, if applicable, Presumptive Eligibility may be determined in lieu of reviewing a Financial Assistance application. Patients who meet any of the criteria for Presumptive Eligibility will be deemed eligible for a discount and will not be asked to submit an application for Financial Assistance.

1.4. A patient may be eligible for Financial Assistance after all other financial resources available to the patient have been exhausted and the patient and patient's family are without sufficient income to cover out of pocket expenses, as determined by TCH. Existing and potential financial resources for the patient, including but not limited to, private health insurance and any Governmental Healthcare Program, will be reviewed.

1.5. Financial Assistance is only applicable to services deemed "medically necessary" by Medicare, Medicaid, or industry standards. In instances where medical necessity is unclear, the Financial Assistance Committee will follow up with the patient's physician to determine whether services are medically necessary.

2. ELIGIBILITY

2.1. Any patient receiving or seeking to receive emergency or medically necessary care at TCH may apply for Financial Assistance. Eligibility for Financial Assistance is generally reserved for U.S. citizens and residents. International and non-resident inquiries are referred to Texas Children's International Patient Services. A patient who is not a U.S. citizen or resident may be considered Financially Indigent or Medically Indigent and the Financial Assistance Committee may approve Financial Assistance for such patient, taking into account the nature of the patient's illness, the likelihood that treatment will lead to a successful outcome, the disposition of similar cases, and the budgetary constraints of TCH.

2.2. Financial Assistance discount percentages, as set forth in Exhibit A attached hereto, are calculated using FPL, and may be updated in conjunction with FPL updates published in the Federal Register.

2.3. If a patient's annual Family Income is 100% or below of the FPL, the patient may qualify for Medicaid. If Family Income is between 101% and 200% of the FPL, the patient may qualify for CHIP. If the patient does not qualify for any Governmental Healthcare Program and Family Income is below 400% of the FPL, the guidelines in Exhibit A Federal Poverty Guidelines will be applied to calculate the percentage of Financial Assistance to which the patient is entitled. Exhibit A Federal Poverty Guidelines will also act as a guideline for the Financial Assistance Deductible. If a patient is not eligible for a 100% discount and would like additional Financial Assistance, such patient's Financial Assistance application will be referred to the Financial Assistance Committee for review and consideration.

2.4. If a patient has Medicare but no secondary coverage and Family Income is within the FPL contained in this Financial Assistance Policy, the patient may be asked to apply for Medicaid prior to being considered for Financial Assistance.

2.5. In addition to using the FPL to determine a patient's eligibility for Financial Assistance, the following factors will be considered:

2.5.1. Family Income: Family Income generally must fall within FPL with consideration to family size, geographic area, and other relevant factors.

2.5.2. If a patient may qualify for coverage, the patient must have applied for and been denied coverage by all potential funding sources, including but not limited to, Medicaid, CSHCN, CHIP, Medicare (if applicable), and/or any potential commercial program.

2.5.3. Employment Status.

2.5.4. Current Financial Obligations (*e.g.* medical debt, tax obligations, child support, mortgages, student loans, etc.).

2.5.5. Good Faith: Patients are expected to cooperate with the application and review process. A parent's failure to cooperate in applying for a government program or financial assistance may be a consideration to deny Financial Assistance.

3. ELIGIBILITY DETERMINATION

3.1. Financial Counselors and Patient Services Specialist will utilize the Federal Poverty Guidelines outlined in Exhibit A to determine the appropriate amount of Financial Assistance available to patients, and the amount of any applicable Financial Assistance Deductible or patient portion due. The Manager, Assistant Director, or Director responsible for Patient Access or Customer Service may approve the request for Financial Assistance in accordance with the guidelines included in Exhibit A Federal Poverty Guidelines. All other applications must be forwarded to the Financial Assistance Committee for approval.

3.2. A patient who can afford to pay for a portion of the services provided by TCH is expected to do so, even if the patient is Medically Indigent. The Financial Assistance Deductible is the amount the patient will be responsible for once approved for Financial Assistance.

A determination of eligibility for Financial Assistance is effective for six months and is applicable toward all outstanding balances incurred during the time period approved. Financial Assistance may be extended for a time period longer than six months as an exception with leadership approval.

3.3. If Financial Assistance is approved, Financial Assistance will apply to balances after all third party payment has been collected. If a patient or any other payer source has made payment during the period of Financial Assistance approval, the payment(s) will be applied to the balance owed by the patient, and Financial Assistance will apply to the remaining balance.

3.4. The Financial Assistance Committee retains the authority to change a previous decision regarding a patient's eligibility for Financial Assistance or may adjust the extent of Financial Assistance on a case by case basis. The Financial Assistance Committee will review:

3.4.1. Cases not compliant for seeking assistance from government programs (refer to section 2.5.5)

3.4.2. Non-US citizen residents with requests for assistance greater than $125,000

3.4.3. Cases requesting financial assistance with an FPL greater than 400%

3.4.4. Cases submitted at the discretion of the Director of Patient Access or Revenue Cycle/Customer Service

3.5. A patient's eligibility for Financial Assistance may be reevaluated when one or more of the following occur:

3.5.1. Subsequent rendering of services;

3.5.2. Change in Family Income;

3.5.3. Family size change;

3.5.4. Six months has elapsed since the patient qualified for Financial Assistance; or

3.5.5. The Financial Assistance process is not completed.

4. AMOUNTS CHARGED TO A PATIENT

4.1. TCH uses a "sliding scale" to determine the percentage discount applicable to a patient who qualifies for Financial Assistance.

4.2. If a patient/family is not eligible to participate in a Government Healthcare Program, TCH offers the following Financial Assistance to Uninsured Self-Pay Patients or Under-insured

Patients using the sliding scale and the most current FPL referenced in Exhibit A Federal Poverty Guidelines:

4.3. With Gross Income between 0% and 200% of the FPL, there is a 100% discount off billed charges.

4.4. With Gross Income between 201% and 300% of the FPL, there is a 75% discount off billed charges.

4.5. With Gross Income between 301% and 400% of the FPL, there is a 55% discount off billed charges.

4.6. With Gross Income greater than 400% of the FPL that do not qualify for Financial Assistance, there is a self-pay discount of charges.

4.7. A Medically Indigent patient is expected to meet his/her Financial Assistance Deductible and be re-evaluated at least every six months to continue receiving financial assistance.

5. BASIS FOR CALCULATING AMOUNTS CHARGED TO PATIENTS

5.1. The amounts charged to patients eligible for Financial Assistance under this Financial Assistance Policy for emergency and medically necessary care will not exceed amounts generally billed ("AGB") to individuals who have insurance covering these types of services. TCH determines AGB for any emergency or medically necessary care it provides to a patient eligible for Financial Assistance under the "look-back" method, which is calculated by multiplying TCH's Gross Charges for the care by a percentage of Gross Charges (the "AGB percentage"). In calculating the AGB percentage (which is done by TCH's Government Reporting department within 120 days before the start of each fiscal year), TCH includes the claims allowed during a prior 12-month period by Medicaid fee-for-service and all private health insurers that pay claims to TCH. TCH begins applying the AGB percentage by the 120th day after the end of the 12-month period used to calculate the AGB percentage.

5.2. Members of the public may readily obtain the applicable AGB percentage and accompanying description for the calculation in writing and free of charge by calling Customer Service at 832-824-2300 or by visiting TCH's Main Admissions Office on the 3rd floor of West Tower, 6621 Fannin St., Houston, Texas 77030.

6. APPLICATION FOR FINANCIAL ASSISTANCE

6.1. A Financial Assistance application may be completed by anyone who requests it or is identified with a need. The applicant is required to sign up for a MyChart account, set up payment plans with automatic drafts/credit charges interest free for a specified timeframe. Exceptions are subject to leadership approval. A sample application is attached as Exhibit B – Financial Assistance Application. Any TCH employee or physician may refer a patient to a Financial Counselor or Patient Services Specialist to initiate a Financial Assistance application. Financial Assistance may be granted at any stage of TCH's revenue cycle.

6.2. The patient or family submitting an application must cooperate with the application process to be considered for Financial Assistance. If a patient does not cooperate with the application process, Financial Assistance may be denied or revoked. Such

cooperation is not a precondition to the receipt of medically necessary treatment or emergency care. When submitting a completed application, the patient is required at a minimum to provide the following documentation: any evidence of third party coverage, employment status, verification of employment and income, proof of residency, and family size.

6.2.1. Proof of household income including any of the following:

6.2.1.1. Most recent federal income tax returns if self employed

6.2.1.2. Last 2 pay check stubs, or written verification of wages from employer, or current W2 forms

6.2.1.3. Unemployment, disability, or child support payments

6.2.1.4. Social Security check or bank statement showing

deposit 6.2.1.5. Most current 2 bank statements

6.3. A Listing of current household expenses such as Mortgage/Rent, Utilities, Loans, Credit Cards, Food, Child Support, Medical and Auto Insurance, Medical Bills/Medications and other types of expenses incurred each month.

6.4. A hardship letter explaining why the patient/family you cannot meet your financial obligation to Texas Children's Hospital is optional.

6.5. Financial assistance screening may be used to determine presumptive eligibility when an application is not possible.

6.6. Patient Access and/or Customer Service will provide a written decision regarding a patient's eligibility for Financial Assistance to the applicant within 60 days of receipt of Financial Assistance determination. This notification will include the discount amount approved and if payment is expected from the patient; the notification does not include specific reasons for the determination.

6.7. A patient whose Financial Assistance application has been denied may appeal such determination through the Patient Financial Services department. Appeals should include supporting documents that demonstrate inability to pay that were not available or included at the time of the initial consideration.

6.8. Patients denied Financial Assistance can request to set up a payment plan administered through Customer Service.

6.9. Patient Financial Services will retain all records relating to Financial Assistance for seven years or stored in electronic form from a third party partner.

6.10. Financial Assistance applications are available at no charge, and can be found online at https://www.texaschildrens.org/financial-assistance, by calling Customer Service at 832-

824-2300 to request that an application by mail, or by visiting TCH's Main Admissions Office on the 3rd floor of West Tower, 6621 Fannin St., Houston, Texas 77030. TCH will provide a translation of its Financial Assistance Policy, Financial Assistance Application,

and a plain language summary of its Financial Assistance Policy to accommodate all significant populations that have limited English proficiency.

6.11. A translated Financial Assistance application can be requested by calling Customer Service at 832-824-2300 or visiting TCH's Main Admissions Office on the 3rd floor of West Tower, 6621 Fannin St., Houston, Texas 77030.

7. NON-PAYMENT

7.1. If a patient does not pay the Financial Assistance Deductible and fails to renegotiate a payment plan (if applicable), the uncollected balance may be considered a Bad Debt and will follow standard Patient/Family Collection Policy and Procedures.

7.2. The guidelines for the management and collection of patient account receivables is described in the Patient/Family Collections Policy in English and Spanish. The link to the webpage: https://www.texaschildrens.org/patients-and-visitors/insurance-and-billing-assistance/financial-arrangements

8. LIST OF PROVIDERS WHO PROVIDE EMERGENCY AND OTHER MEDICALLY NECESSARY CARE AT TCH

8.1. TCH maintains a list of providers (which is updated each fiscal quarter), other than TCH and its substantially related entities, who provide emergency and other medically necessary care at TCH facilities and are covered by TCH's Financial Assistance Policy. A copy of such list of providers is available at no charge, and can be found online at https://www.texaschildrens.org/financial-assistance, or by calling Customer Service at 832-824-2300 to request a list by mail, or by visiting TCH's Main Admissions Office on the 3rd floor of West Tower, 6621 Fannin St., Houston, Texas 77030.

9. AVAILABILITY OF THE FINANCIAL ASSISTANCE POLICY, PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY, AND FINANCIAL ASSISTANCE APPLICATION

9.1. TCH will make information regarding Financial Assistance widely available to all patients. TCH will offer information that includes this Financial Assistance Policy, the Financial Assistance application, instructions on applying, and a plain language summary of this Financial Assistance Policy on its website (available at http://www.texaschildrens.org/Financial_Assistance.aspx). In addition, this information will be available upon request and without charge, both by mail and in public places within TCH, including the Emergency Center and Admission areas. TCH will notify and inform members of the community served by TCH about this Financial Assistance policy by publishing the information annually in the local newspaper as well as on patient guarantor

statements. TCH will also have public displays that notify and inform patients about this Financial Assistance Policy. Information will be available in English, Spanish, or other languages spoken by significant populations served by TCH. Patients can contact TCH for information regarding Financial Assistance. Financial Counseling may be reached at

832-824-5505 for Main Campus, 832-227-2120 for West Campus and 832-826-3300 for Pavilion for Women. Information is also available through Customer Service at 832-824-2300.

10. EXCEPTIONS

10.1. Extenuating circumstances may arise in determining eligibility for patients who do not meet the above established criteria. The Financial Assistance Committee is charged with reviewing and approving such cases.

RELATED DOCUMENTS

Exhibit A Federal Poverty Guidelines

Patient/Family Collections Policy

Patient/Family Collections Procedure

Exhibit B – Financial Assistance Application

Admissions Policy

REFERENCES

ASSOCIATED LAWS AND REGULATIONS
TEXAS HEALTH AND SAFETY CODE ANN. §§ 311.031-311.048
TEXAS TAX CODE § 153.310, § 171.063
Medicaid Conditions of Participation
Section 501(r) of the Internal Revenue Code of 1986, as amended, and the Treasury Regulations promulgated thereunder

ASSOCIATED LAWS AND REGULATIONS

TEXAS HEALTH AND SAFETY CODE ANN. §§ 311.031 - 311.048 TEXASTAXCODE § 153.310, § 171.063
Medicaid Conditions of Participation
Patient Protection and Affordable Care Act of 2010 section 501 (r)

Operations Committee:	05/12/10
Creation Date:	01/05/1989
Effective Date:	04/30/14
	05/14/10

POLICY and PROCEDURE

Original Document Creation Date: 01/05/1989	This Version Creation Date: 09/25/2018	Effective/Publication Date: 10/01/2018

Version #: 7

EXHIBIT A: FEDERAL POVERTY GUIDELINES are updated annually and published on the Federal Register

Example: 2019 FPG effective January 2019

2019 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	Poverty guideline
For families/households with more than 8 persons, add $4,420 for each additional person.	
1	$12,490
2	$16,910
3	$21,330
4	$25,750
5	$30,170
6	$34,590
7	$39,010
8	$43,430

TEXAS CHILDREN'S HOSPITAL
FINANCIAL ASSISTANCE REQUEST
(SOLICITUD DE SERVICIOS SIN COMPENSACION)

As provided by Federal law, I/we ask Texas Children's Hospital to determine if I/we are eligible for help in paying for our child's hospital bill. I/we understand that I/we need to give certain information for this to be done. I/we also understand that Texas Children's Hospital or its agents will check these facts for accuracy. I/we understand that filling out this form does not guarantee that I/we will receive this help. If I am (we are) not eligible for uncompensated services, I am (we are) responsible for my child's hospital bill. *(De acuerdo con las leyes federales, solicitó/solicitamos a Texas Children's Hospital que decidida si soy/somos elegibles para recibir ayuda para pagar la factura del hospital de nuestro niño/a. Entiendo/entendemos que para esto necesito/necesitamos proporcionar cierta información. También comprendo/comprendemos que Texas Children's Hospital o sus agentes verifican la veracidad de esta información. Entiendo/entendemos que el llenar esta forma no garantiza que recibiré/recibiremos dicha ayuda. Si no soy/somos elegibles para servicios sin compensación, asumo/asumimos responsabilidad por el pago de la factura de hospital de mi niño/a)*

PATIENT INFORMATION
(INFORMACION DEL PACIENTE)

Previous Patient? Yes or No *(Paciente anterior)* *(SI)* *(NO)*			
Patient's First Name: *(Primer Nombre del Paciente)*		**Patient's Last Name:** *(Apellido del Paciente)*	
Street Address: *(Domicilio)*			
Phone Number: *(Teléfono)*		**SSN:** *(Número de Seguro Social)*	- -
Date of birth: *(Fecha de Nacimiento)*		**Place of Birth:** *(Lugar de Nacimiento)*	
Religion: *(Religión)*		**Gender:** *(Sexo)*	M or F
Ethnicity: (circle one) *(Grupo étnico)*	White / Black / Hispanic / Asian / Asian/Pacific Islander / Other		
Is the patient a U.S. Citizen? *(El paciente es ciudadano americano?)*		**Yes or No** *(Si) (No)*	
Is the Patient a legal U.S.Resident? *(El paciente es residente legal de U.S.?)*		**Yes or No** *(Si) (No)*	
Has financial assistance been requested previously? *(Anteriormente ha solicitado asistencia financiera?)*		**Yes or No If yes, when?** *(SI) (NO) (Si, Cuando?)*	
Potential Third Party Payor Source (circle one) *(Tiene seguro medico o otro tipo de plan, circule el plan) (circule una)*		Private Insurance / Medicaid/Medicaid HMO / Medicare CHIP / CHCN / Other:	
Physician's Name: *(Nombre de el Médico)*		**Diagnosis:** *(Diagnostico)*	

PARENT/GUARDIAN INFORMATION
(INFORMACION DE PADRE/GUARDIAN)

Mother's Name: *(Nombre de la Madre)*		**Mother's Last Name:** *(Apellido de la Madre)*	
Date of Birth: *(Fecha de Nacimiento)*		**SSN:** *(Número de Seguro Social)*	

TEXAS CHILDREN'S HOSPITAL
FINANCIAL ASSISTANCE REQUEST
(SOLICITUD DE SERVICIOS SIN COMPENSACION)

Employer Name: *(Nombre del Empleador)*		**Work Phone:** *(Numero de Teléfono de trabajo)*	
Employer Address: *(Domicilio del Empleador)*			

Father's Name: *(Nombre de el Padre)*		**Father's Last Name:** *(Apellido de el Padre)*	
Date of Birth: *(Fecha de Nacimiento)*		**SSN:** *(Número de Seguro Social)*	
Employer Name: *(Nombre del Empleador)*		**Work Phone:** *(Numero de Teléfono de trabajo)*	
Employer Address: *(Domicilio del Empleador)*			

HOUSEHOLD INFORMATION
(INFORMACION DE CASA)

Number of Family Members living in household *(Numero de miembros de familia que viven en la casa)*

Name *(Nombre)*	**Relationship** *(Relación)*	**Age** *(Edad)*	**Gender** *(Sexo)*

INCOME INFORMATION
(INGRESO DE SALARIO)

Must provide photocopies of check-stubs and bank statements for the last two (2) months
(Favor de proveer fotocopias de los talones de cheque y estados de cuenta del banco de los últimos dos meses)

Wages (self) *(Salario propio)*	$
Wages (spouse) *(Salario de el esposo)*	$
Wages (other family members living in household) *(Salario de otros miembros de la familia viviendo en su casa)*	$
Farm or Self-Employment *(Granja o Auto empleo)*	$

TEXAS CHILDREN'S HOSPITAL FINANCIAL ASSISTANCE REQUEST (SOLICITUD DE SERVICIOS SIN COMPENSACION)	
Public Assistance *(Asistencia publica)*	$
Social Security Benefits *(Beneficios de Seguro Social)*	$
Unemployment Compensations *(Compensación por desempleo)*	$
Alimony *(Pensión Alimenticia)*	$
Child Support *(Pensión Infantil)*	$
Military Family Allotments *(Asignación familiar militar)*	$
Pensions *(Pensiones)*	$
Income from Dividends, Interest, Rental Property *(Ingreso de dividendos, intereses, renta de propiedades)*	$
Trust Fund(s) *(Fondos fiduciarios o fideicomisos)*	$
Other Income (Retirement/Disability, etc.) *(Otros Ingresos)*	$
TOTAL INCOME *(Ingreso Total)*	**/Monthly**

EXPENSES (GASTOS)	
Mortgage/Rent *(Renta/Hipoteca)*	$
Auto Loans *(Prestamos de Automóvil)*	$
Utilities *(Servicios de luz, agua, etc.)*	$
Food *(Comida)*	$
Loans *(Prestamos)*	$
Credit Cards *(Tarjetas de crédito)*	$
Alimony/Child Support *(Pensión Alimenticia/Pensión Infantil)*	$
Medical Insurance *(Seguro de Medico)*	$
Auto Insurance *(Seguro de Auto)*	$
Medical Bills *(Cuentas Medicas)*	$

TEXAS CHILDREN'S HOSPITAL FINANCIAL ASSISTANCE REQUEST (SOLICITUD DE SERVICIOS SIN COMPENSACION)	
Medications *(Medicamentos)*	$
Other *(Otros gastos)*	$
TOTAL EXPENSES	**/Monthly**

PROPERTY (PROPIEDAD)		
Do you own a home? Yes/No *(Es propietario de una casa)*	**If yes, estimated home value $** *(Valor Estimado de su casa)*	**Amount Owed$** *(Cantidad de debe en su casa)*
Do you own other property? Yes/No *(Es propietario de una propiedad)*	**If yes, estimated property value $** *(Valor Estimado de su propiedad)*	**Amount Owed$** *(Cantidad de debe en su propiedad)*

AUTOMOBILES		
Model/Make *(Marca/Modelo)*	**Year** *(Ano)*	**Value** *(Valor)*

	SIGNATURES (FIRMAS)
	I/we declare under penalty of perjury that the answers I/we have given are true and correct to the best of my/our knowledge. *(Declaro/declaramos, bajo protesta de decir verdad que las respuestas aquí incluidas son ciertas y verdaderas, de acuerdo a mis/nuestros conocimientos.)*
	I/we agree to tell the provider of services, within 10 days, if there are any changes in my (or the persons on whose behalf I am (we are acting) income, property, expenses, or in the person in the household or of any change of addresses. *(Estamos de acuerdo en informar al proveedor de servicios, dentro de un periodo de 10 días, sobre cualquier cambio en mi (nuestro) ingreso, propiedad, gastos, personas que viven en el hogar mío (nuestro o de la(s) persona(s) a nombre de la cual estamos realizando este tramite.)*
	I/we understand that I/we may be asked to prove my statements and that my/our eligibility statements will be subject to verification by contact with my employer, bank, credit verification, and property searches. *(Comprendo/comprendemos que es posible que se nos solicite que demos prueba de nuestras declaraciones, y que la elegibilidad esta sujeta a ser verificada contactando a mi empleador, bando, verificación de crédito y búsqueda de propiedades.)*

TEXAS CHILDREN'S HOSPITAL FINANCIAL ASSISTANCE REQUEST (SOLICITUD DE SERVICIOS SIN COMPENSACION)	
	I/we understand that the county and hospital are required by law to keep any information I/we provide confidential. *(Comprendo/comprendemos que la ley obliga al condado y al hospital a mantener la confidencialidad de la información proporcionada por mi/nosotros.)*
	I/we further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county or hospital from proceeds of any litigation or settlement resulting from such act. *(Además de esto, estoy/estamos de acuerdo en que, en consideración por recibir servicios de atención medica como resultado de un accidente o lesión, reembolsaremos al condado o al hospital cualquier fondo recaudado por algún litigio o acuerdo que resultase de dicho acto.)*
	I/we understand that if I/we do not qualify for uncompensated services, I/we will be personally liable for the charges of the services rendered by Texas Children's Hospital or I/we may appeal decision in writing with additional documentation. *(Entiendo/entendemos que si no calificamos para servicios sin compensación, seré/seremos directamente responsables de los cargos por servicios prestados por Texas Children's Hospital, o podremos apelar la decisión por escrito con documentación adicional.)*

X	**Date:**
Signature of Mother/Guarantor: *(Firma de la Madre/Guardián)*	
X	**Date:**
Signature of Father/Guarantor: *(Firma del Padre/Guardián)*	

FOR TCH USE ONLY		
Previous Financial Assistance Approved	**Approved Amount:**	**Approved Date:**
Previous Financial Assistance Denied	**Denied Amount:**	**Denied Date:**
Type of Service: Hospital Inpatient Outpatient/Clinic Hospital Emergency Room Take Home Pharmacy		
Amount Requested	$	

TEXAS CHILDREN'S HOSPITAL FINANCIAL ASSISTANCE REQUEST (SOLICITUD DE SERVICIOS SIN COMPENSACION)	
Total Income	$
Total Deductions	$
Difference	$
Comments/Other Notes:	
X	**Date:**
Signature Financial Counselor/Accounts Representative	
X	
Print Name	