500 E Border Street #122
Arlington Texas 76010
682-236-1600 / 800-715-7210
customerservice@texastexashealthpartners.com

日期 / *Date*：__________ 担保人姓名 / *Guarantor Name*：______________________

患者姓名 / *Patient Name*：______________________________

医□服□日期 / *Date of Service*：_____________

医院□号 / *Hospital Account #*____________________________

病□号 / *Medical Record #* _____________

☐	Texas Health Center for Diagnostics & Surgery Plano	☐	Texas Health Harris Methodist Hospital Southlake	☐	Texas Health Presbyterian Hospital Flower Mound
☐	Texas Health Presbyterian Hospital Rockwall	☐	Texas Institute for Surgery at Presbyterian Hospital of Dallas		

尊敬的患者 / *Dear Patient*：

所附□德克□斯州□生□源□政援助申□表。完成本申□会使我□能□在支付医院□□□提交您的□□，考□是否可□得□政援助。 <u>只能用于支付您的医院□用。</u> / *Attached you will find the Texas Health Resources Financial Assistance Application. Completion of this application will enable us to present your account for consideration of financial assistance for your hospital bill(s). <u>This is for your hospital charges only.</u>*

我□知道您享有□私□。 因此，除了□□用途外，您申□中所包含的信息将被□□机密信息。 只有在需要知道的情况下才在德克□斯州□生□源机构分享□些信息。 / *We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential information. It will only be shared within Texas Health Resources on a need to know basis.*

□完成申□表的各□内容。 如果您需要□外空□□行□明，□使用申□表的背面。 / *Please complete each item on the application. If you need additional space for any explanations, please utilize the back of the application.*

□提供您当月和前两个月的工□□复印件和/或任何其他形式的家庭收入□明。 如果您没有收到支票存根，□提供□示您每月存款的□行□□□复印件。 如果是自雇人□，□提供您最近提交的个人所得税□税申□表复印件和当期□益□表。 未能提供所要求的文件可能会□致拒□考□提供□政援助。 / *Please provide copies of your current month and two prior months pay stubs and/or proof of any other form of income for the household. If you do not receive check stubs, please provide copies of your bank statements showing your monthly deposits. If self-employed, please provide a copy of your most recently filed personal income tax return and a current profit and loss statement. Failure to provide the requested documentation can result in a denial for financial assistance consideration.*

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您在收到本申□表后尽快填好并交回极其重要。。 / *It is extremely important that you complete this application upon receipt and return it as soon as possible.*

如果您完成本申□表有困□或有不清楚的地方，□来□咨□。□□您的合作。 / *If you have difficulty completing this application or there is an area that is unclear, please call. Your cooperation is appreciated.*

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□政援助申□ — — 第 1 □ / APPLICATION FOR FINANCIAL ASSISTANCE – Page 1

患者姓名 / *Patient Name* : 姓 / *Last* ________ 名 / *First* ________ 中□名 / *MI* __

社安号 / *Social Security #*______ 出生日期 / *DOB* : _____ 医院□号 / *Hospital Account #* : _____

已婚 / *Married*__ 未婚 / *Single*___ 离异 / *Divorced*____ □偶 / *Widowed*___ 分居 / *Separated*______

您是否有未成年子女（18 □以下）？ / *Do you have minor children (under 18)?*	_____	是 / *Yes*	____	否 / No
他□是否与您一起生活? / *Do they live with you?*	_____	是 / *Yes*	____	否 / No
他□是否□您□生/合法□养的孩子？ / *Are they your birth/legally adopted children?*	_____	是 / *Yes*	____	否 / No
患者是否有工作？ / *Patient Employed?*	_____	是 / *Yes*	____	否 / No
配偶是否有工作? / *Spouse Employed?*	_____	是 / *Yes*	____	否 / No
您是否有医□保□? / *Do you have medical insurance?*	_____	是 / *Yes*	____	否 / No
您是否残疾? 多□□□？ / *Are you on disability? How long?*	_____	是 / *Yes*	____	否 / No
您是否退伍□人? / *Are you a veteran?*	_____	是 / *Yes*	____	否 / No

家庭成□ — — (在家里生活) / *FAMILY MEMBERS – (Living in the home)*

配偶 / *Spouse* : ____________________

孩子 / *Child* : ____________________ 年□ / *Age* : ________

孩子 / *Child* : ____________________ 年□ / *Age* : ________

孩子 / *Child* : ____________________ 年□ / *Age* : ________

孩子 / *Child* : ____________________ 年□ / *Age* : ________

收入（每月金□） / *INCOME (Monthly Amount)* :

	毛收入 / *Gross*	□收入 / *Net*	支出 / *Expenses*	每月金□ / *Monthly Amount*
患者 / *Patient*	$	$	按揭/租金 / *Mortgage/Rent*	$
配偶 / *Spouse*	$	$	公用事□□ / *Utilities*	$
家属 / *Dependents*	$	$	汽□开支 / *Car Payments*	$
公共援助 / *Public Assistance*	$	$	食品 / □□ / *Food / Groceries*	$
食品券 / *Food Stamps*	$	$	信用卡 / *Credit Cards*	$
社会保障 / *Social Security*	$	$	其他 (□注明) / *Other (please specify)*	
失□ / *Unemployment*	$	$	________	$
□工福利 / *Strike Benefits*	$	$		
工人的补偿 / *Worker's Compensation*	$	$	□□ / *TOTAL*	$
□养□ / *Alimony*	$	$		
子女□养□ / *Child*	$	$		

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Support	______	______
□用□款 / *Military Allotments*	$______	$______
养老金 / *Pensions*	$______	$______
收入来源 / *Income from*： 定期存款 / *CD's*		
租金、股息 / *Rent, Dividends*		
利息 / *Interest*	$______	$______
□□ / *TOTAL*	$______	$______

□□ / *ASSETS*

支票□□ / *Checking Account*	$______
□蓄□□ / *Savings Account*	$______
定期存款、个人退休金□□ / *CD's, IRA's*	$______
其他投□ （股票、 □券等） / *Other Investments (Stocks, bonds, etc.)*	$______
主住宅以外的房□/土地 / *Properties/Land other than primary residence*	$______

□政援助申□ — — 第 2 □ / *APPLICATION FOR FINANCIAL ASSISTANCE – Page 2*

雇主名称 / *Name of Employer*	______	配偶的雇主 / *Spouse's Employer* :	______
□□ / *Telephone #*	______	□□ / *Telephone #*	______
雇主地址 / *Employer Address*	______	雇主地址 / *Employer Address*	______
□□ / *Occupation*	______	□□ / *Occupation*	______

您目前是否正在申□医□□助（ Medicaid）福利？ / *Are you currently applying for Medicaid Benefits?*	___ 是 / *Yes*	___ 否 / No
您是否已□通□□医院/扶□□划申□了援助？ / *Have you applied for assistance thru your county hospital/indigent program?*	___ 是 / *Yes*	___ 否 / No
您的医生是否免□□您提供服□？ / *Is your physician donating his/her services?*	___ 是 / *Yes*	___ 否 / No
是否可能存在□承担□任的第三方□您的事故/□害/疾病□□？ / *Are there any potentially liable third-parties responsible for your accident/injury/illness?*	___ 是 / *Yes*	___ 否 / No
是否有人援助您支付医院□□？ / *Is anyone assisting you with payment of your hospital bills?*	___ 是 / *Yes*	___ 否 / No
□在援助您？ / *Who is assisting you?*	______	
您目前收到多少援助？ / *How much assistance are you receiving?*	______	

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□列出您□□有助于我□确定您是否有□格□得支付医院□□援助的任何其他信息。 / *List any other information you feel would be helpful to us in determining your eligibility for assistance in paying your hospital bill.*

____

____

____

在您因病休息期□将收到的□期收益和/或□金（病假、□薪休假、短期/□期□残收入） / *Expected earnings and/or funds you will receive during your time off due to your illness (Sick leave, paid time off, short/long term disability income)*。

$_______________

您无法工作和/或□取工□的□期□□□度 / *Expected length of time you will be unable to work and/or earn wages* :

____

我明白德克□斯州□生□源机构可能□□本申□中包含的与医院□本申□□估相关的□政信息，并据此授□医院□系我的雇主以□明所提供的信息和索要信用□告机构的□告。 我知道，□些信息将用于确定我是否有□格□得□政援助，本申□中的虚假信息可能会□致拒□□政援助。 我□明白，如果从第三方或其他来源□取援助，可能会全部或部分撤消所批准的任何□政援助。 / *I understand that Texas Health Resources may verify the financial information contained in this application in connection with the hospital's evaluation of this application, and hereby authorize the hospital to contact my employer to certify the information provided and to request reports from credit reporting agencies. I am aware that this information will be used to determine my eligibility for financial assistance and that the falsification of information in this application may result in denial of Financial Assistance care assistance. I also understand that any Financial Assistance approval may be completely or partially reversed in the event of a recovery from a third-party or other source.*

我□明白，不□将我收到的任何□政援助支付的□理服□解□□医院放弃其□我□□欠款的留置□，而且我收到的与本次住院相关的任何□□必□送到德克□斯州□生□源机构。 / *I further understand that any Financial Assistance care I receive shall not be construed as a waiver by hospital of its hospital lien for reimbursement of any amount I owe and that any reimbursement I receive relating to this hospitalization must be sent to Texas Health Resources.*

____	________________
申□人□名（患者） / *Signature of Person Making Request, If Patient*	日期 / *Date*
申□人□名（非患者） / *Signature of Person Making Request, If Not Patient*	关系 / *Relationship*

患者地址 / *Patient's Address*	城市 / *City*	州 / *State*	□□ / *ZIP*	□ / *County*	住宅□□号□ / *Home Telephone Number*