Arlington Memorial Hospital
Harris Methodist Hospitals
Presbyterian Hospitals

500 E Border Street #130
Arlington Texas 76010
682-236-3000 / 800-890-6034
THRFinancialAssistance@texashealth.org

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

患者姓名 / *Patient Name* : ________________________________

医疗服务日期 / *Date of Service* : _____________

医院账号 / *Hospital Account #*_____________________________

病历号 / *Medical Record #* _____________

	Texas Health Arlington Memorial Hospital		Texas Health Harris Methodist Hospital Southwest Fort Worth		Texas Health Presbyterian Hospital Dallas
	Texas Health Harris Methodist Hospital Alliance		Texas Health Harris Methodist Hospital Springwood		Texas Health Presbyterian Hospital Denton
	Texas Health Harris Methodist Hospital Azle		Texas Health Harris Methodist Hospital Stephenville		Texas Health Presbyterian Hospital Kaufman
	Texas Health Harris Methodist Hospital Cleburne		Texas Health Heart & Vascular Hospital Arlington		Texas Health Presbyterian Hospital Plano
	Texas Health Harris Methodist Hospital Fort Worth		Texas Health Outpatient Surgery Center Alliance		Texas Health Specialty Hospital Fort Worth
	Texas Health Harris Methodist Hospital Hurst-Euless-Bedford		Texas Health Presbyterian Hospital Allen		

尊敬的患者 / *Dear Patient* :

所附为德克萨斯州卫生资源财政援助申请表。完成本申请会使我们能够在支付医院账单时提交您的账户，考虑是否可获得财政援助。 只能用于支付您的医院费用。 / *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). This is for your hospital charges only.*

我们知道您享有隐私权。 因此，除了验证用途外，您申请中所包含的信息将被视为机密信息。 只有在需要知道的情况下才在德克萨斯州卫生资源机构分享这些信息。 / *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.*

请完成申请表的各项内容。 如果您需要额外空间进行说明，请使用申请表的背面。 / *Please complete each item on the application. If you need additional space for any explanations, please utilize the back of the application.*

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请提供您当月和前两个月的工资单复印件和/或任何其他形式的家庭收入证明。 如果您没有收到支票存根，请提供显示您每月存款的银行对账单复印件。 如果是自雇人员，请提供您最近提交的个人所得税纳税申报表复印件和当期损益报表。 未能提供所要求的文件可能会导致拒绝考虑提供财政援助。 / *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.*

您在收到本申请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.*

如果您完成本申请表有困难或有不清楚的地方，请来电咨询。谢谢您的合作。 / *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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财政援助申请 —— 第 1 页 / APPLICATION FOR FINANCIAL ASSISTANCE – Page 1

患者姓名 / *Patient Name*： 姓 / *Last* ____________ 名 / *First* ____________ 中间名 / *MI* __

社安号 / *Social Security #*______ 出生日期 / *DOB*：_____ 医院账号 / *Hospital Account #*：__

已婚 / *Married*_ 未婚 / *Single*___ 离异 / *Divorced*___ 丧偶 / *Widowed*___ 分居 / *Separated*__

问题 / Question				
您是否有未成年子女（18 岁以下）？ / *Do you have minor children (under 18)?*	_____	是 / *Yes*	_____	否 / No
他们是否与您一起生活? / *Do they live with you?*	_____	是 / *Yes*	_____	否 / No
他们是否为您亲生/合法领养的孩子？ / *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
您是否有医疗保险? / *Do you have medical insurance?*	_____	是 / *Yes*	_____	否 / No
您是否残疾? 多长时间？ / *Are you on disability? How long?*	_____	是 / *Yes*	_____	否 / No
您是否退伍军人? / *Are you a veteran?*	_____	是 / *Yes*	_____	否 / No

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

配偶 / *Spouse*： ____________________

孩子 / *Child*： ____________________ 年龄 / *Age*：

孩子 / *Child*： ____________________ 年龄 / *Age*：

孩子 / *Child*： ____________________ 年龄 / *Age*：

孩子 / *Child*： ____________________ 年龄 / *Age*：

收入（每月金额） / *INCOME (Monthly Amount)*：

	毛收入 / *Gross*	净收入 / *Net*
患者 / *Patient*	$	$
配偶 / *Spouse*	$	$
家属 / *Dependents*	$	$
公共援助 / *Public Assistance*	$	$
食品券 / *Food Stamps*	$	$
社会保障 / *Social Security*	$	$
失业 / *Unemployment*	$	$
罢工福利 / *Strike Benefits*	$	$
工人的补偿 / *Worker's Compensation*	$	$
赡养费 / *Alimony*	$	$
子女抚养费 / *Child*	$	$

支出 / *Expenses*	每月金额 / *Monthly Amount*
按揭/租金 / *Mortgage/Rent*	$
公用事业费 / *Utilities*	$
汽车开支 / *Car Payments*	$
食品 / 杂货 / *Food / Groceries*	$
信用卡 / *Credit Cards*	$
其他（请注明）/ *Other (please specify)*	$
总计 / *TOTAL*	$

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Support

军用拨款 / *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*	$	$
总计 **/** *TOTAL*	$	$

资产 / *ASSETS*

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

财政援助申请 —— 第 2 页 / *APPLICATION FOR FINANCIAL ASSISTANCE – Page 2*

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

您目前是否正在申请医疗补助（ Medicaid）福利? / *Are you currently applying for Medicaid Benefits?*	是 / *Yes*	否 / No
您是否已经通过县医院/扶贫计划申请了援助？ / *Have you applied for assistance thru your county hospital/indigent program?*	是 / *Yes*	否 / No
您的医生是否免费为您提供服务？ / *Is your physician donating his/her services?*	是 / *Yes*	否 / No
是否可能存在应承担责任的第三方对您的事故/伤害/疾病负责？ / *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账单？ / *Is anyone assisting you with payment of your hospital bills?*	是 / *Yes*	否 / No

谁在援助您？ / *Who is assisting you?*

您目前收到多少援助？ / *How much assistance are you receiving?*

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请列出您认为有助于我们确定您是否有资格获得支付医院账单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.*

____

____

____

在您因病休息期间将收到的预期收益和/或资金（病假、带薪休假、短期/长期伤残收入） / *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/或赚取工资的预期时间长度 / *Expected length of time you will be unable to work and/or earn wages*：

____

我明白德克萨斯州卫生资源机构可能验证本申请中包含的与医院对本申请评估相关的财政信息，并据此授权医院联系我的雇主以证明所提供的信息和索要信用报告机构的报告。 我知道，这些信息将用于确定我是否有资格获得财政援助，本申请中的虚假信息可能会导致拒绝财政援助。 我还明白，如果从第三方或其他来源获取援助，可能会全部或部分撤消所批准的任何财政援助。 / *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.*

我还明白，不应将我收到的任何财政援助支付的护理服务解释为医院放弃其对我偿还欠款的留置权，而且我收到的与本次住院相关的任何补偿必须送到德克萨斯州卫生资源机构。 / *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.*

____ ______________
申请人签名（患者） / *Signature of Person Making Request, If Patient* 日期 / *Date*

____ ______________
申请人签名（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* 邮编 / *ZIP* 县 / *County* 住宅电话号码 / *Home Telephone Number*