Wise Health System

Affiliated with, but not controlled by, Baylor Health Care System or its subsidiaries or community medical centers

GUARANTOR NAME_____
Last **First** **M.I**

ADDRESS_____
Street **City, State** **Zip**

_____ _____ _____ _____
Social Security # **Date of birth** **Home Phone** **Employer and work Phone**

_____ _____ _____
Spouse **Date of birth** **Employer and work number**

Minor Dependent _____**Date of birth** _____

Minor Dependent _____ **Date of birth**_____

Minor Dependent _____ **Date of birth** _____

If more space is needed for minor dependents please use additional page – minor dependents must be claimed on income tax to be claimed on application

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VERIFICATION OF INCOME MUST BE AT LEAST FOR THE LAST THREE MONTHS. YOU MAY USE A COPY OF YOUR SOCIAL SECURITY CHECK OR COPIES OF YOUR DIRECT DEPOSIT. YOU WILL NEED TO PROVIDE COPIES OF ALL SAVINGS AND CHECKING ACCOUNTS. YOU WILL BE REQUIRED TO SHOW PROOF THAT YOU HAVE APPLIED FOR AND BEEN DENIED ASSISTANCE FOR ANY OTHER GOVERNMENT ASSISTANCE PROGRAMS.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE; I WILL APPLY FOR ANY ASSISTANCE SUCH AS MEDICAID, MEDICARE, OR INSURANCE, WHICH MAY BE AVAILABLE, FOR PAYMENT OF MY HOSPITAL CHARGES. IF ANY INFORMATION I HAVE GIVEN IS OF A FALSE NATURE, I UNDERSTAND THAT THE HOSPITAL MAY REEVALUATE MY FINANCIAL STATUS AND TAKE WHATEVER ACTION BECOMES APPROPRIATE.

DISCLAIMER: *APPROVAL OF WRHS ASSISTANCE PROGRAM DOES NOT RELEASE YOU OF ANY OBLIGATION WITH YOUR OTHER HEALTH CARE PROVIDERS;*

DATE OF REQUEST:_____**SIGNATURE:**_____

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Eligibility Determination (For Office Use Only)

Denied for charitable assistance due to _____

Approved for Charitable Assistance: ☐ Charity Level _____ for _____ dependants claimed
☐ Medical Indigency.

$_____ yearly income: Processed by _____

2000 S. FM 51 X Decatur, TX 76234 Hospital Phone 940-627-5921 Fax 940-626-1226

NOTICE OF AVAILABILITY FOR FINANCIAL ASSISTANCE

Wise Health System has a Financial Assistance program available. Reasonable amounts of service will be provided without charge to those who cannot afford to pay for care.
The complimentary care is eligible for those without any other pay source.

To be eligible to receive financial assistance at 100%, your family income must be at 300% or below the National Poverty Guideline as outlined below.

Family Size	Yearly Income	Monthly Income
1	$36,180.00	$3,015.00
2	$48,720.00	$4,060.00
3	$61,260.00	$5,105.00
4	$73,800.00	$6,150.00
5	$86,340.00	$7,195.00
6	$98,880.00	$8,240.00
7	$111,420.00	$9,285.00
8	$123,960.00	$10,330.00
FOR EACH FAMILY MEMBER ABOVE 8 ADD $4,180.00		

If you think you may be eligible for uncompensated services, you may request the form from the hospital. Wise Health System will make a written conditional or final determination for services. ***Applications may be requested in person or by telephone.*** *You may contact the business office for further questions regarding the program.*