# *We accept the following insurance plans:*

**STAR**
- Amerigroup Star
- Community Health Choice
- Texas Health Network
- Texas Children's Star

**STAR PLUS**
- Amerigroup Star Plus
- Evercare Star Plus
- Texas Health Network Star Plus

- Evercare Choice

**Children's Health Insurance Program (CHIP)**
- Amerigroup CHIP
- Choice One CHIP
- Texas Children's CHIP

**PPO**
- Blue Cross/Blue Shield

**INDEMNITY**
- Blue Cross/Blue Shield "Member Contract"

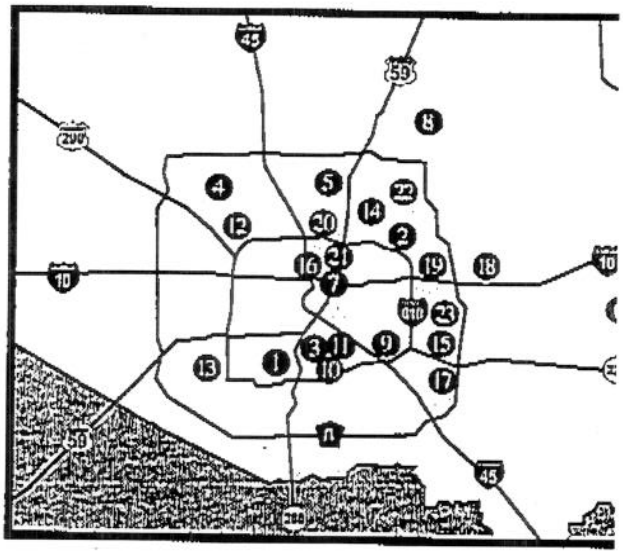
**OBSTETRICAL SERVICES**
- Veterans Administration

HCHD community
HCHD Gold Cards

*If you would like to visit a Harris County Hospital District doctor, call the HCHD Appointment Center.*

***713-526-HCHD (713-526-4243).***

*Tell them which clinic from the list below you would like to visit.*



Hospitals

1. Ben Taub General Hospital, 1504 Taub Loop, Houston, TX 77030, 713-873-2000
2. LBJ General Hospital, 5656 Kelley Street, Houston, TX 77026, 713-566-5000
3. Quentin Mease Community Hospital, 3601 North MacGregor, Houston, TX 77004, 713-873-3700

Community Health Centers

4. Acres Home Health Center, 818 Ringold Street, Houston, TX 77088, 281-448-6391
5. Aldine Health Center, 4755 Aldine Mail Route, Houston, TX 77039, 281-985-7600
6. Baytown Health Center, 1602 Garth Road, Baytown, TX 77520, 281-837-2700
7. Casa De Amigos Health Center, 1615 N. Main, Houston, TX 77009, 713-222-2272
8. E.A. "Squatty" Lyons Health Center, 1712 First St., Suite M-20, Humble, TX 77338, 281-446-4139
9. Gulfgate Health Center, 7550 Office City Drive, Houston, TX 77012, 713-495-3700
10. HCHD Dental Center, 5230 Griggs Road, Houston, TX 77021, 713-757-0572
11. Martin Luther King Health Center, 3601 North MacGregor, Houston, TX 77004, 713-873-4700
12. Northwest Health Center, 1100 W. 34th Street, Houston, TX 77018, 713-861-3939
13. People's Health Center, 6630 De Moss, Houston, TX 77074, 713-272-2600
14. Settegast Health Center, 9105 North Wayside, Houston, TX 77028, 713-633-2020
15. Strawberry Health Center, 927 Shaw Road, Pasadena, TX 77506, 713-982-5900
16. Thomas Street Health Center, 2015 Thomas Street, Houston, TX 77009, 713-873-4000

School Based Clinics

17. Deepwater Clinic, Deepwater Elementary School, 309 Glenmore Drive, Pasadena, TX 77503, 832-668-8380
18. Jerry Neal Clinic, Channelview High School, 828 1/2 Sheldon Road, Channelview, TX 77530, 281-457-6350
19. Almatha Clark Taylor Clinic, Cloverleaf Elementary School, 14002 Bundera, Houston, TX 77015, 713-330-8904
20. Patrick Henry Clinic, Patrick Henry Middle School, 10702 East Hardy, Houston, TX 77093, 713-696-2731
21. Robert Carrasco Clinic, Sherman Elementary School, 1909 McKee, Houston, TX 77009, 713-226-2632
22. Smiley Clinic, Smiley High School, 10726 Mesa Road, Houston, TX 77078, 713-636-8185
23. Southside Clinic, Galena Park Community Resource and Training Center, 1721 16th Street, Galena Park, TX 77547, 713-671-2461

**Harris County Hospital District**

*Got a healthcare question? We'll answer it 24/ Call Ask Your Nurse at 713-632-225*

# Aceptamos los siguientes seguros:

MEDICAID

**STAR**

- Amerigroup Star
- Community Health Choice
- Texas Health Network
- Texas Children's Star

**STAR PLUS**

- Amerigroup Star Plus
- Evercare Star Plus
- Texas Health Network Star Plus

MEDICARE

- Evercare Choice

SEGURO COMERCIAL

**Children's Health Insurance Program (CHIP)**

- Amerigroup CHIP
- Choice One CHIP
- Texas Children's CHIP

**PPO**

- Blue Cross/Blue Shield

**INDEMNITY**

- Blue Cross/Blue Shield "Member Contract"

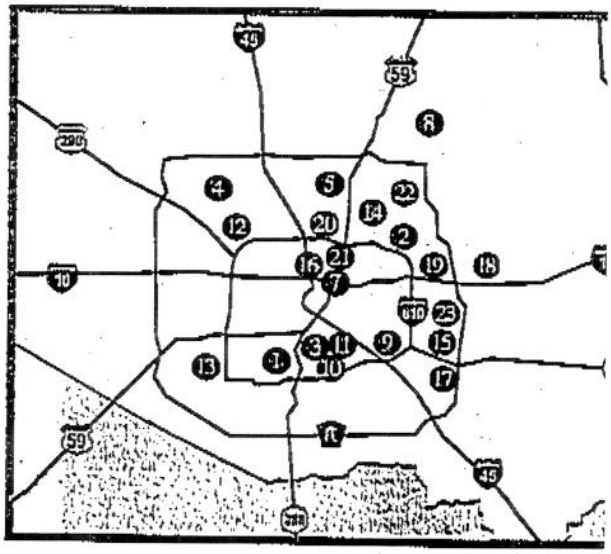
**OBSTETRICAL SERVICES**

- Veterans Administration

HCHD community

*Si usted desea hacerse atender por un médico del Distri de Hospitales del Condado de Harris, llame al Centro d Citas del HCHD al* ***713-526-4243.***

*Dígales en qué clinica de la lista que aparece a continuación desea usted ser atendido.*



Hospitales

1. Ben Taub General Hospital
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   Houston, TX 77030
   713-873-2000

2. LBJ General Hospital
   5656 Kelley Street
   Houston, TX 77026
   713-566-5000

3. Quentin Mease Community Hospital
   3601 North MacGregor
   Houston, TX 77004
   713-873-3700

Centros de Salud Comunitarios

4. Acres Home Health Center
   818 Ringold Street
   Houston, TX 77088
   281-448-6391

5. Aldine Health Center
   4755 Aldine Mail Route
   Houston, TX 77039
   281-985-7600

6. Baytown Health Center
   1602 Garth Road
   Baytown, TX 77520
   281-837-2700

7. Casa De Amigos Health Center
   1615 N. Main
   Houston, TX 77009
   713-222-2272

8. E.A. "Squatty" Lyons Health Center
   1712 First St., Suite M-20
   Humble, TX 77338
   281-446-4139

9. Gulfgate Health Center
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   Houston, TX 77012
   713-495-3700

10. HCHD Dental Center
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    713-757-0572

11. Martin Luther King Health Center
    3601 North MacGregor
    Houston, TX 77004
    713-873-4700

12. Northwest Health Center
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    Houston, TX 77018
    713-861-3939

13. People's Health Center
    6630 De Moss
    Houston, TX 77074
    713-272-2600

14. Settegast Health Center
    9105 North Wayside
    Houston, TX 77028
    713-633-2020

15. Strawberry Health Center
    927 Shaw Road
    Pasadena, TX 77506
    713-982-5900

16. Thomas Street Health Center
    2015 Thomas Street
    Houston, TX 77009
    713-873-4000

Clínicas Escolares

17. Deepwater Clinic
    Deepwater Elementary School
    309 Glenmore Drive
    Pasadena, TX 77503
    832-668-8380

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    Houston, TX 77078
    713-636-8185

23. Southside Clinic
    Galena Park Community Resource and Training Center
    1721 16th Street
    Galena Park, TX 77547
    713-671-2461

Harris County Hospital District

*¿Tiene alguna pregunta acerca de su sali*
*Respondemos las 24 hor*

# Make The Right Call.

## Poison Control Center
## 1-800-222-1222

If you have a poison emergency, call the poison control center immediately. Experts will help you if someone has breathed, eaten or touched chemicals, or has taken the wrong medicine.

## The City of Houston Information
## 3-1-1

3-1-1 connects you to city services 24 hours a day. Representatives will direct you to the right person, help you with traffic tickets, operating hours, or a neighborhood problem.

## Crisis Hotline
## 713-Hotline (468-5463)

Feeling stressed, depressed, or thinking of suicide and don't know where to turn? Call the Crisis Hotline 24 hours a day and talk privately about your problems.

## United Way Help Line (TEXAS)
## 2-1-1

Need help and don't know who to call? 2-1-1 helps you find out about food, shelter, counseling, after school programs, senior services, disaster relief and other resources.

## Ask Your Nurse
## 713-633-CALL (2255)

Feeling sick, but not sure if you need to see your doctor or go to the hospital? Call to talk to nurses for answers to your health questions.

## Emergency 9-1-1
## (Police-Fire-Medical Emergencies)

Call 9-1-1 only for life or property threatening emergencies needing police, fire or ambulance. The easy-to-remember phone number can be dialed from any phone, including wireless.

# Haga la Llamada Correcta.

## Centro del Control de Venenos
## 1-800-222-1222

Si tiene una emergencia de envenenamiento llame de inmediato al Centro de Control de Venenos. Personas expertas le ayudarán si alguien ha aspirado, tragado o tocado químicos o si ha tomado una medicina equivocada.

## Información en la Ciudad de Houston
## 3-1-1

El 3-1-1 le comunica con los servicios municipales 24 horas del día. Sus representantes le informarán quién es la persona apropiada para ayudarle con sus infracciones de tránsito, horario de trabajo o con un problema en su vecindario.

## La línea Telefónica de Crisis
## 713-Hotline (468-5463)

¿Se siente tenso, deprimido o con pensamientos suicidas y no sabe a quien acudir? Llame a la Linea de Crisis las 24 horas del día para hablar en privado de sus problemas.

## La línea de Ayuda de United Way (TEXAS)
## 2-1-1

¿Necesita ayuda y no sabe a quien llamar? El 2-1-1 le ayuda a buscar recursos como alimentos, refugio, asesoría, programas fuera de la escuela, servicios para personas mayores y socorro en caso de desastres.

## Pregunte a Su Enfermera
## 713-633-CALL (2255)

¿Se siente enfermo pero no está seguro si necesita visitar al doctor o ir al hospital? Llame y hable con una enfermera, ella dará respuesta a sus preguntas sobre la salud.

## Emergencia 9-1-1
## (Policía - Incendio- Emergencias Médica)

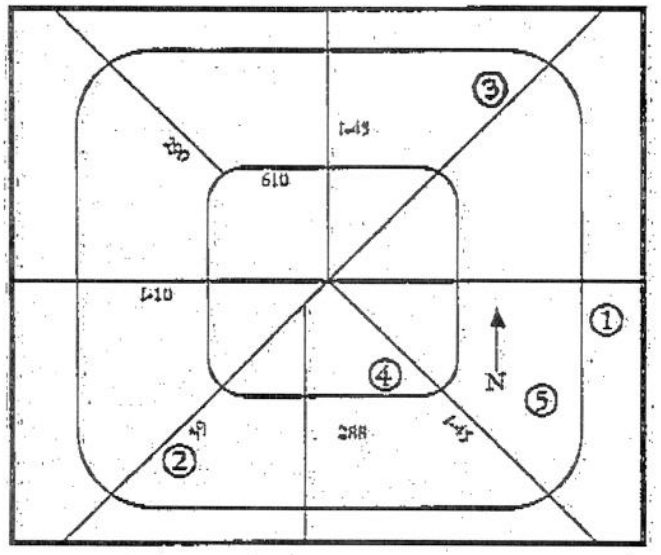
Llame al 9-1-1 solamente si está en peligro una vida o la propiedad; en una emergencia que necesite a la policía, los bomberos o una ambulancia. Este número se puede marcar desde cualquier teléfono incluyendo celulares.

# Harris County Hospital District

## Eligibility Centers
## Centros de Eligibilidad

### register today!

Registering for a Gold Card is one of the best things you can do for yourself, and for your family. For your convenience, there are several eligibility centers strategically located throughout Harris County. You should decide which center is most convenient for you.




1 Baytown Eligibility Center
281-427-6757
1602 Garth Road, Baytown, TX 77520

2 Southwest Eligibility Center
713-995-3500
6654 Hornwood, Houston, TX 77074

3 East Mount Houston Eligibility Center
281-372-3100
11737 E. Mount Houston, Houston, TX 77039

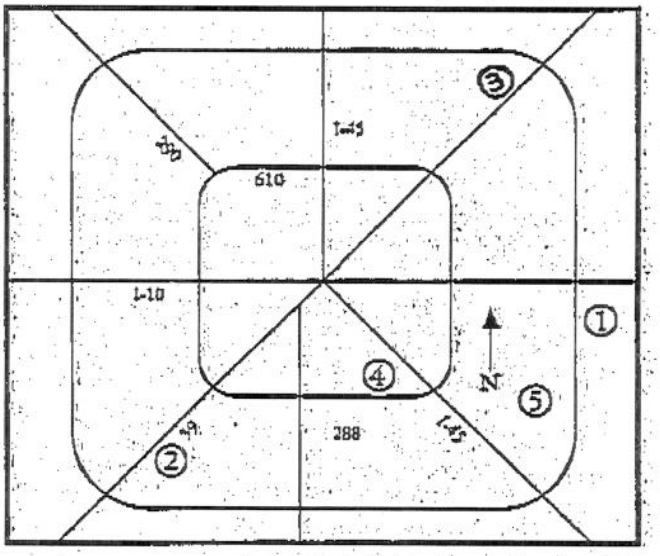
4 South Loop Eligibility Center
713-643-3691
5959 Long Drive, Houston, TX 77087

5 Strawberry Eligibility Center
713-740-8180
925 Shaw Rd, Pasadena, TX 77506

Once you receive your Gold Card, you will be assigned to the Community Health Program Clinic closest to your home. The assigned clinic is where you and your family will receive your primary healthcare.

### ¡Regístrese hoy!

Registrarse para obtener una Tarjeta Dorada es una de las mejores cosas que usted puede hacer por usted mismo, y por su familia. Para su conveniencia, hay varios centros de eligibilidad estratégicamente ubicados a lo largo del Condado de Harris. Usted deberá decidir cual es el centro que le resulta más conveniente.




1 Centro de Eligibilidad Baytown
281-427-6757
1602 Garth Road, Baytown, TX 77520

2 Centro de Eligibilidad Southwest
713-995-3500
6654 Hornwood, Houston, TX 77074

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713-643-3691
5959 Long Drive, Houston, TX 77087

5 Centro de Eligibilidad Strawberry
713-740-8180
925 Shaw Rd, Pasadena, TX 77506

Una vez que reciba su Tarjeta Dorada, le asignarán la clínica del Programa Comunitario de Salud más cercano a su domicilio. La clínica asignada es donde usted y su familia recibirán su cuidado primario de salud.

# Harris County Hospital District

## *Early Detection, Prevention and Community Outreach Division*

**Providing FREE health services in your community**

## *Information on how to seek financial assistance for Hospital District healthcare services*

***Services available in English and Spanish***

## *Health Education Presentations*

The following is a list of awareness presentations to present to your group or agency. Presentations may be adapted to suit the audience and agency's needs. Additional topics are available.

| | | |
|---|---|---|
| Access to HCHD | Healthy Eating | Physical Fitness |
| Alzheimer's Disease | Healthy Heart | Prostate Health |
| Arthritis | High Blood Pressure | Puberty |
| Breast Health | HIV/AIDS | Senior Health |
| Child Abuse Awareness | Immunizations | Sexually Transmitted Diseases |
| CHIP | Menopause | Skin Health |
| Cholesterol | Mental Health | Stress Management |
| Depression | Methods of Contraception | Substance Abuse |
| Diabetes | Oral Health | Teen Health |
| Domestic Violence | Osteoporosis | Tuberculosis |
| General Cancer | Personal Hygiene | Vial of Life |

**Please call 713-566-6064 to schedule an outreach event**

## *Health Fair Participation*

- Free Screenings
- Health Literature
- HCHD Information

**Call the Health Fair Line at 713-566-6718**

**Community Sites Include:**

*Churches, Schools, Day care centers, Senior centers, Apartment complexes, Community centers, Libraries, Head Start centers, Non-profit organizations, and many others!*

**2525 Holly Hall, Houston TX 77054 Phone: 713-566-6064 Fax: 713-566-6040**

## APPLICATION FOR ASSISTANCE
## HARRIS COUNTY HOSPITAL DISTRICT

Financial assistance from the Harris County Hospital District (HCHD) helps people pay for needed medical care received at HCHD facilities. Whether you can get this help depends on your income, where you live, other help you receive or could receive, and other items.

You may turn in or mail back your application, even if you cannot answer all the questions. However, if you do not answer all questions, your application will be incomplete, and HCHD will be unable to determine if you are eligible for financial assistance.

Try to answer as many questions as you can on this application. Be sure to:

- Answer all questions in Item 1, General Information, and
- Sign and date the last page of the application.

You can turn in your application to any eligibility center, or mail or fax it to:

HCHD Financial Assistance Program
c/o Patient Eligibility Services
PO Box 300488
Houston, TX 77230
Fax: (713) 566-6670

Once your application is received, you will be contacted to arrange an appointment for an interview.

### YOUR RESPONSIBILITIES

You must provide proof of any information that is written on your application, or given to the interviewer. If you need help getting proof, the person interviewing you will help. Or, you can ask to see the manager at the interview location.

Examples of some of the things you will be asked to prove and things you can use for proof are:

- YOUR IDENTITY AND IDENTITY OF FAMILY MEMBERS
  Possible proof: Driver's license or Texas Identification card, student ID with picture, employee job badge with picture, passport with picture, U.S. Immigration documents with picture, credit card with picture, ID issued by foreign consulates, marriage license, birth certificates, Social Security card, U.S. naturalization, citizenship or other federal documents, hospital or birth records, adoption papers or records, voter's registration card, or wage stubs.
- WHERE YOU LIVE AND PLAN TO CONTINUE LIVING:
  You will need two proofs: one dated within the past 60 days and the other dated up to one year ago. Possible proof: utility bills; lease agreement; school records for minor children; mortgage coupon; rental verification form; Department of Motor Vehicles record; credit card statement; property tax statement; automobile insurance documents; automobile registration; printout from IRS of current tax year filing; certification documents or benefits checks from the Social Security Administration or Texas Workforce Commission; certification documents from Food Stamps, Medicaid or Medicare; letter from recognized social services agency; mail addressed to you or your spouse; statement from child care provider; current voter's registration card; Texas driver's license; ID card issued by the Department of public safety; domicile verification form completed by a reliable third person, post office records; city or criss-cross directory; telephone directory; or church records.
- HOUSEHOLD INCOME FOR THE PAST 30 DAYS
  Possible proof: pay check stubs; pay checks; W-2 tax forms; wage verification letter; current year 1040 tax form; benefit letters; retirement checks or statements.
- HOUSEHOLD COMPOSITION (who lives with you)
  Possible proof: birth certificate; baptismal record; most recent IRS 1040 form; Social Security Award letter for dependents; school documents; insurance documents; U.S. Immigration application; divorce or child support decree; baby's Papras form, birth fact record, or hospital armband); proof of school enrollment for students aged 18-23.
- IMMIGRATION STATUS
  You do not have to be a U.S. citizen to qualify for financial assistance. However, if you are not a citizen, and you have documentation from the INS, it must be presented to determine your eligibility for assistance.
- OTHER HEALTH CARE COVERAGE
  Possible proof: award or claim letters; insurance policies; court document; other legal papers.
- RESOURCES
  If you have Medicare coverage and you want to apply for a discount on services and fees not covered by Medicare, you must provide proof of your resources and liabilities.

Information on race and sex is voluntary. Information on Social Security Numbers should be given if available. These types of information will not change your eligibility.

You must give information about medical insurance and other third party financially liable for medical services paid under this program for yourself and members of your household. By signing and submitting this application, you are agreeing to give HCHD the right to recover the cost of health care services provided by HCHD from any third party.

You may be asked to apply for Medicaid, TANF (Temporary Assistance for Needy Families) or SSI (Supplemental Security Income) benefits. If you are asked to apply for one of these programs, you may still be eligible for assistance from HCHD for a limited period of time. If you are not eligible for these other programs, if you have answered all questions on the application, and if you have given all the proof asked for, you application is complete.

After turning in your application, you must report within 14 days any changes in your address, income, people living with you, or application for (or receipt of) SSI, AFDC, or Medicaid. Failure to report these changes may result in losing your assistance from HCHD.

If you are qualified for financial assistance and it is later determined that the information or proof you provided on this application was false, you may lose your financial assistance, may be barred from reapplying for six months, and be required to repay HCHD for any services rendered. You may also be charged with criminal and/or civil penalties.

If you need assistance, ask to speak to a manager, or call (713) 566-6691.

Your Name: _____

Your application was received:

# HARRIS COUNTY HOSPITAL DISTRICT
## APPLICATION FOR FINANCIAL ASSISTANCE

**This is an Official Government Record. Untrue or incomplete information given on this form may and probably will result in Criminal Action being taken under Sections 31.04, 37.04, 37.10, or other portions of the Texas Penal Code.**

| Applicant's Name (Last, First, Middle) | | | Home Telephone No. | | Work Telephone No. |
|---|---|---|---|---|---|
| Mailing Address- (Street or P.O. Box) | Apt. # | City | State | ZIP | County |
| Home Address (If different from above) | | | | | |
| Have you ever used another name? ☐ Yes ☐ No | | List other names you have used: | | | |
| Why are you asking for help now? | | How did you meet your expenses until now? | | | |

1. Fill in line (a) about yourself. Fill in the remaining blanks for everyone who lives with you, whether or not you consider them household members:

| NAME (Last, First, Middle) | WHAT RELATIONSHIP TO YOU? | DATE OF BIRTH | SEX | RACE | U.S. CITIZEN | | LEGAL ALIEN | | IN SCHOOL | | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Y | N | Y | N | Y | N | |
| Applicant (a) | SELF | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| (d) | | | | | | | | | | | |
| (e) | | | | | | | | | | | |
| (f) | | | | | | | | | | | |
| (g) | | | | | | | | | | | |
| (h) | | | | | | | | | | | |

2. Are you married or common-law married? ..... ☐ Yes ☐ No

3. Is anyone in your household disabled? ..... ☐ Yes ☐ No

   If "yes", whom? _____

4. List all of your household's income below:

| NAME OF PERSON WORKING OR RECEIVING MONEY | NAME OF EMPLOYER, PERSON, OR AGENCY THAT PROVIDES THE MONEY | HOW OFTEN RECEIVED? | AMOUNT RECEIVED | IF SOCIAL SECURITY, ENTER CLAIM NO. |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| TOTAL INCOME | | | $ | |

5. Have you or has anyone living with you worked in the past three months? ..... ☐ Yes ☐ No

**HARRIS COUNTY HOSPITAL DISTRICT**
**APPLICATION FOR FINANCIAL ASSISTANCE**

6. Living arrangements:

Check all boxes that apply to your household:

☐ Own or Paying for Home ☐ No Permanent Residence ☐ Renting
☐ Migrant or Seasonal Farmworker ☐ Live with Relatives or Friends

| Monthly Rent or Payment | Monthly Utilities | Telephone | Tax on Home | Insurance on Home | Does anyone else pay these expenses for you? |
|---|---|---|---|---|---|
| $ | $ | $ | $ | $ | ☐ Yes ☐ No |

7. Are you or is anyone who lives with you pregnant?..... ☐ Yes ☐ No

If "Yes," who? _____

8. Does anyone have unpaid medical bills from the last four months?..... ☐ Yes ☐ No

9. Does anyone have health insurance?..... ☐ Yes ☐ No
If "No", does anyone have access to health insurance through an employer?..... ☐ Yes ☐ No

| NAME OF PERSON INSURED | NAME OF THE POLICY HOLDER | NAME OF EMPLOYER PROVIDING INSURANCE | NAME OF INSURANCE | POLICY NUMBER | INS. CO. TELEPHONE NO. |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

10. Give your household's county and state of residence (where you make your permanent home):

County: _____ State: _____

11. Do all the listed people who want assistance plan to stay in this county and state as residents?..... ☐ Yes ☐ No

12. Have you or a member of your household applied for SSI?..... ☐ Yes ☐ No

If "Yes," who applied? _____ Date applied: _____

13. If you are unemployed, complete the information below:

I, _____ (your name), am unemployed. My income per month is $ _____, which is from _____ (source of income). Additional monthly income for my immediate family comes from _____ (source) and totals $ _____ per month. I(we) have no other source of income, including savings, real property, or rental property. My last employer was: Company Name _____, Address: _____, Telephone Number: _____.

**HARRIS COUNTY HOSPITAL DISTRICT**
**APPLICATION FOR FINANCIAL ASSISTANCE**

14. If you are self-employed and do not file taxes, complete the information below:

I, _____ (your name) am presenting _____ (bookkeeper's statement, receipts, etc.) to prove my total gross monthly income which is $_____. My profession is _____.

15. If you are a housewife, complete the information below:

I, _____ (your name), am a housewife. I do not earn any income in or out of my home. The last date I worked was _____. I am not on a leave of absence from a job. I have been a housewife for the following length of time: _____. My source of support is: _____.

16. If you are separated from your spouse, complete the following information:

I, _____ (your name) acknowledge that I have been separated for _____ (duration) from _____ (spouse's name), who lives at (address): _____. My spouse provides me with $_____ monthly.

17. If you are supported by a someone other than your spouse, the person who supports you must complete the following information:

I, _____ (name of supporter) acknowledge that I have supported _____ (client's name) for the following length of time: _____.

I do ☐ do not ☐ provide him/her with room and board. My relationship to him/her is _____. I understand that I am not responsible for his/her medical bills unless I have a legal responsibility to support him/her. My source of income is _____. Signature: _____ Date: _____

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief.

I agree to give HCHD eligibility staff any information necessary to prove statements about my eligibility. I will cooperate fully with county personnel in a quality control review or audit.

I agree to report any of the following changes within 14 days:
- Income,
- Number of people who live with me,
- Address,
- Application for or receipt of SSI, TANF, or Medicaid.

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief; that I may request a review of the decision made on my application or recertification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt of or stopping assistance.

I understand that by signing this application, I am giving HCHD the right to recover the cost of health care services provided by HCHD from any third party. I agree to give the county any information it needs to identify and locate all other sources of payment for health care services.

I have been told and understand that my failure to meet the obligations set forth may be considered willful withholding of information and can result in the recovery of any loss by repayment, or by filing criminal or civil charges against me.

**BEFORE YOU SIGN, BE SURE EACH ANSWER IS COMPLETE AND CORRECT**

_____ _____
Signature – Applicant Date

## SOLICITUD DE ASISTENCIA
## DISTRITO HOSPITALARIO DEL CONDADO DE HARRIS

La asistencia financiera del Distrito Hospitalario del Condado de Harris (HCHD) ayuda a las personas a pagar servicios médicos recibidos en instalaciones del HCHD.
Esta ayuda se brinda de acuerdo al ingreso monetario de la familia, la vivienda, otro tipo de asistencia financiera que recibe o recibirá y otros aspectos.

Puede entregar personalmente su solicitud o enviarla por correo, aunque no pueda responder todas las preguntas. Sin embargo, si no responde todas las preguntas, su solicitud estará incompleta y el HCHD no podrá determinar si usted reúne los requisitos necesarios para considerar la asistencia financiera.

Trate de responder la mayor cantidad de preguntas posibles de la solicitud. Asegúrese de:

- Responder todas las preguntas del primer punto, proporcione toda la información general y
- Firme y consigne la fecha en la última página de la solicitud.

Puede entregar personalmente su solicitud en cualquier centro de elegibilidad, enviarla por correo o por fax a:

HCHD Financial Assistance Program
c/o Patient Eligibility Services Administration
P.O. Box 300488
Houston, TX 77230
Fax: 713 566 6670

Una vez recibida su solicitud, nos comunicaremos con usted para programar una entrevista.

### SUS RESPONSABILIDADES

Le solicitaremos comprobantes de la información que nos proporcionó en su solicitud o a la persona que le entrevistó. Si necesita ayuda para obtener los comprobantes, la persona que le entreviste le ayudará o podrá solicitar la intervención del supervisor en donde se lleva a cabo la entrevista.

Ejemplos de algunas cosas que le pediremos que compruebe o que podrá usar como comprobantes:

- SU IDENTIFICACIÓN PERSONAL Y LA DE LOS MIEMBROS DE SU FAMILIA
  Posibles comprobantes: Licencia de Conducir o Identificación personal del estado de Texas, identificación estudiantil con fotografía, identificación de trabajo con fotografía, pasaporte con fotografía, documentos de inmigración con fotografías, tarjeta de crédito con fotografía, identificaciones extendidas por consulados extranjeros, licencia matrimonial, certificados de nacimiento, tarjeta del Seguro Social, certificado de naturalización, certificado de ciudadanía u otros documentos federales, registro hospitalario o de nacimiento, certificados de adopción, tarjeta de votante o talones de cheques.
- DONDE VIVE Y DONDE PLANEA CONTINUAR VIVIENDO:
  Necesitará dos comprobantes: uno con fecha en los 60 días pasados y el otro con la fecha de un año atrás. Posibles comprobantes: recibos de servicios públicos, contrato de alquiler, documentos escolares de los niños o menores, recibo de hipoteca, formulario de verificación del alquiler, documentos del Departamento de Vehículos automotores, estado de cuenta de tarjetas de crédito, recibo de impuestos a la propiedad, comprobantes del
seguro del automóvil, registro automotor, copia de la declaración impositiva anual más reciente, documentos certificados o cheques de beneficio de la Administración del Seguro Social o de la Comisión Laboral de Texas, documentos certificados de las estampillas para alimentos, Medicaid o Medicare, carta de agencia de servicios sociales reconocida, correspondencia dirigida a usted o a su cónyuge, recibo de la persona u institución donde cuidan a los niños, tarjeta de votante actualizada, Licencia de conducir o Identificación personal de Texas emitidas por el Departamento de Seguridad Pública, formulario de verificación domiciliaria que completa por un tercera persona respetable, comprobantes de la oficina postal, directorio entrecruzado o de la ciudad, directorio telefónico comprobantes de archivos religiosos.
- COMPROBANTES DE INGRESOS DE LOS PASADOS 30 DÍAS.
  Posible comprobante: talones de los cheques de pago, cheques de pago; la Forma W-2 de impuestos, carta de verificación de salario, Forma No. 1040 de los impuestos del corriente año, cartas de beneficio, cheques de pensión o jubilación.
- COMPOSICIÓN DEL HOGAR (quienes viven con usted)
  Posibles comprobantes: certificado de nacimiento, certificado de bautismo, el formulario de declaración de impuestos 1040 más reciente, carta donde se otorga Seguro Social a los dependientes, documentos escolares, comprobantes de seguros, documentación de solicitud de inmigración a los EE.UU., decreto de divorcio o cuota de alimentos para menores, la forma Poprns del nacimiento, el acta de nacimiento o el brazalete del Hospital, comprobante de registro escolar para estudiantes de 18 a 23 años.
- ESTATUS MIGRATORIO
  No tiene que ser ciudadano americano para la elegibilidad de asistencia financiera. Sin embargo, si no es ciudadano y tiene documentos del Servicio de Inmigración y Naturalización debe presentarlos para determinar si reúne los requisitos para obtener la asistencia.
- OTROS SEGUROS DE SALUD
  Posibles comprobantes: carta de reclamo o de provisión de seguro, pólizas de seguro, comprobantes de la corte u otros documentos legales.
- RECURSOS
  Si tiene cobertura de Medicare y quiere solicitar un descuento en los servicios y cargos que Medicare no cubre, deberá proporcionar los comprobantes de sus recursos y responsabilidad financiera.

La información correspondiente al sexo y al grupo étnico es voluntaria. Deberá proporcionar la información correspondiente a los números de seguro social, si la tiene disponible. Este tipo de información no cambiará su situación de elegibilidad.

Debe proporcionar la información correspondiente a los seguros de salud y a las terceras personas con responsabilidad financiera por servicios médicos pagados por ese programa para usted y para miembros de su familia. Al firmar y remitir esta solicitud, usted acuerda darle al HCHD el derecho para recuperar el costo de los servicios médicos proporcionados por el HCHD de algún tercero.

Se le pedirá que solicite Medicaid, TANF (Asistencia Temporaria para Familias Necesitadas) o beneficios de SSI (Ingreso Suplementario de Seguridad ). Si le piden que solicite uno de estos programas, es posible que continúe siendo elegible para recibir asistencia financiera del HCHD por un período de tiempo limitado. Si no es elegible para estos programas, si ha respondido todas las preguntas de la solicitud y si facilita todos los comprobantes necesarios, su solicitud está completa.

Después de remitida su solicitud, antes de los 14 días debe reportar si hubo cualquier cambio de domicilio, ingresos, personas que viven con usted o los recibos de sus solicitudes (o recibo de) de

SSI, AFDC o Medicaid . Si no reporta estos cambios puede perder la asistencia del HCHD.

Si usted reúne los requisitos para la asistencia financiera y luego se determina que la información o que los comprobantes presentados eran falsos, podrá perder su asistencia financiera, puede impedirse que vuelva a solicitar asistencia financiera por seis meses y que se requiera el pago al HCHD por los servicios brindados. También se le puede responsabilizar de cargos criminales y/o pena civil.

Si necesita asistencia, pida hablar con un supervisor o llame al 713-566-6691.

Su nombre: _____

Su solicitud fue recibida el:

# DISTRITO HOSPITALARIO DEL CONDADO DE HARRIS
## SOLICITUD DE ASISTENCIA FINANCIERA

**Este es un documento gubernamental oficial. La información falsa o incompleta puede resultar en Acción criminal de acuerdo a las Secciones 31.04, 37.04, 37.10 u otras secciones del Código Penal de Texas.**

| Nombre del Solicitante (Apellido, Nombre, Segundo Nombre) | | Teléfono particular | | Teléfono del trabajo | |
|---|---|---|---|---|---|
| Domicilio Postal (Calle o Apartado Postal) | Dpto. # | Ciudad | Estado | Código Postal | Condado |
| Domicilio Particular (Si es diferente al anterior) | | | | | |
| ¿Ha usado otro nombre? ☐ Sí ☐ No | Lista de nombres usados | | | | |
| ¿Por qué solicita ayuda ahora? | ¿Cómo cubrió sus gastos hasta ahora? | | | | |

1. Complete la línea (a) su información. Complete los espacios a continuación con todas las personas que viven con usted, los considere o no parte de su hogar.

| Nombre (Apellido, Nombre, Segundo Nombre) | Parentesco con usted | Fecha de Nacimiento. | SEX | Race | Ciudad. Amer | | Extranj. Legal | | En la Escuela | | NUMERO DE SEGURO SOCIAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Sí | No | Sí | No | Sí | No | |
| Solicitante (a) | USTED MISMO | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| (d) | | | | | | | | | | | |
| (e) | | | | | | | | | | | |
| (f) | | | | | | | | | | | |
| (g) | | | | | | | | | | | |
| (h) | | | | | | | | | | | |

2. ¿Está casado o vive en unión libre (en pareja)?..... ☐ Sí ☐ No

3. ¿Alguien en su casa está discapacitado?..... ☐ Sí ☐ No

Si la última respuesta es afirmativa, ¿quién? _____

4. A continuación detalle todos los ingresos de su hogar:

| Nombre de la persona que trabaja o recibe dinero | Nombre del empleador, persona o agencia que le paga | ¿Con qué frecuencia? | ¿Qué cantidad? | No. de reclamo del Seguro Social |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| INGRESO TOTAL: | | | $ | |

5. ¿Usted o alguien que vive con usted ha trabajado en los últimos 3 meses? _____ ☐ Sí ☐ No

**DISTRITO HOSPITALARIO DEL CONDADO DE HARRIS**
**SOLICITUD PARA ASISTENCIA FINANCIERA**

6. Organización de la vivienda:

Marque todos los casilleros correspondientes a su vivienda:
☐ Casa propia o hipoteca ☐ No es su residencia permanente ☐ Alquiler
☐ Trabajador temporal en cosechas o migratorio ☐ Vive con familiares o amigos

| Pago de renta mensual | Servicios Públicos mensuales | Teléfono | Impuestos de la casa | Seguro de la casa | ¿Alguien le paga estos gastos? |
|---|---|---|---|---|---|
| $ | $ | $ | $ | $ | ☐ Sí ☐ No |

7. ¿Está usted o alguien que vive con usted embarazada? _____ ☐ Sí ☐ No

Si la respuesta anterior es afirmativa, ¿quién? _____

8. ¿Alguien en su casa tiene pagos médicos pendientes en los pasados cuatro meses? _____ ☐ Sí ☐ No

9. ¿Alguien tiene seguro médico? _____ ☐ Sí ☐ No
Si la respuesta es negativa, ¿tiene alguien acceso a seguro de salud a través de un empleador? _____ ☐ Sí ☐ No

| NOMBRE DE LA PERSONA ASEGURADA | NOMBRE DEL TITULAR DE LA PÓLIZA | NOMBRE DEL EMPLEADOR QUE PROVEE EL SEGURO | NOMBRE DE LA COMPAÑÍA DE SEGUROS | NÚMERO DE PÓLIZA | TELÉFONO DE LA COMPAÑÍA DE SEGUROS |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

10. Nombre del Condado y del Estado donde reside permanentemente (donde está su hogar permanente):
Condado: _____ Estado: _____

11. ¿Las personas en la lista que requieren asistencia planean quedarse en este condado y en este estado como residentes?
☐ Sí ☐ No

12. ¿Usted o alguien en su casa ha solicitado SSI? _____ ☐ Sí ☐ No

Si la respuesta anterior es afirmativa, ¿Quién lo solicitó? _____ Fecha de la solicitud _____

13. Si está desempleado, por favor complete la siguiente información:
Yo, _____ (su nombre), estoy desempleado. Mi ingreso mensual es de $ _____, que recibo de _____(de donde proviene el ingreso). El ingreso mensual adicional de mi familia inmediata viene de _____(de donde proviene) y el total es $ _____ por mes. Yo (nosotros) no tengo/ tenemos otros recursos financieros, incluyendo ahorros, propiedad inmobiliaria o de alquiler. Mi último empleador fue:

Nombre de la Compañía _____, Domicilio _____.

Teléfono _____.

**DISTRITO HOSPITALARIO DEL CONDADO DE HARRIS**
**SOLICITUD PARA ASISTENCIA FINANCIERA**

14. **Si usted es trabajador independiente y no reporta impuestos,** complete la información a continuación:

Yo, _____(su nombre) estoy presentando _____

(comprobantes contables, recibos, etc.) para comprobar que mi ingreso bruto mensual es de $ _____. Mi profesión es

_____.

15. Si usted es **ama de casa,** complete la información a continuación:
Yo, _____ (su nombre) soy ama de casa. No recibo ningún ingreso ni en mi casa ni fuera de mi sa. La última vez

que trabajé fue el _____. No estoy de licencia sin goce de sueldo en mi trabajo. He sido ama de casa por _____.

Mi recurso financiero para vivir es: _____

16. Si está **separada de su cónyuge,** complete la información a continuación:

Yo, _____ (su nombre) reconozco que he estado separada por _____

(duración) de _____ (nombre del cónyuge), que vive en (domicilio): _____

_____. Recibo mensualmente de mi cónyuge $ _____.

17. Si **lo/ la mantiene otra persona que no es su cónyuge,** la persona que la/ lo mantiene debe completar la siguiente información:

Yo, _____ (nombre de la persona que lo/ la mantiene) reconozco que he mantenido a _____

_____ (nombre del cliente) por el siguiente período de tiempo: desde _____hasta _____

Yo, le proporciono ☐ no le proporciono ☐, casa y comida. Mi relación con esta persona es de _____.

Entiendo que no soy responsable por sus cuentas de gastos médicos a menos que tenga una responsabilidad legal por la cual mantenerla/ lo. El

origen de mis ingresos es_____Firma: _____ Fecha: _____

Declaro haber dicho la verdad en lo que a mí concierne, mis respuestas a todas las preguntas son correctas y respondí de buena fe.

Estoy de acuerdo en proporcionar la información necesaria al personal de elegibilidad del HCHD para comprobar mi declaración acerca de mi elegibilidad. Cooperaré absolutamente con el personal del condado en cuanto al control de calidad o auditoría.

Estoy de acuerdo en reportar los siguientes cambios dentro de los 14 días:

- Ingresos
- Cantidad de personas que viven conmigo
- Domicilio
- Solicitud de un recibo de SSI, TANF o de Medicaid.

Se me ha informado y entiendo que esta solicitud será considerada sin tener en cuenta la raza, el color, la religión, el credo, el país de origen, la edad, el sexo, la discapacidad o la inclinación política; que podré apelar respecto a la decisión correspondiente a mi solicitud o a una re-certificación para asistencia; que podré solicitar en persona o por escrito una audiencia acerca de las acciones que afecten la recepción o la cancelación de la asistencia.

Entiendo que al firmar esta solicitud, le otorgo al HCHD el derecho de recuperar de terceros el costo de los servicios de asistencia médica recibidos y que hubiera proporcionado el HCHD. Me comprometo a brindar la información pertinente y necesaria para identificar y para localizar los recursos financieros para los servicios de asistencia médica.

Se me ha informado y entiendo que si no cumplo con las obligaciones que se me adjudicaron, esto puede considerarse retención voluntaria de información y en consecuencia la recuperación de cualquier pago o la demanda civil y criminal en mi contra.

**ANTES DE FIRMAR, ASEGÚRESE QUE LAS RESPUESTAS ESTÉN CORRECTAS Y COMPLETAS**

_____ _____
**Firma del solicitante** **Fecha**

## Facts at a Glance

The Harris County Hospital District (HCHD) is the nation's fourth largest public metropolitan health system. In 2002, HCHD accommodated more than 1 million emergency and outpatient visits and delivered more than 10,000 babies to area residents. During the past five years, hospital district facilities have encountered more than 5.5 million total patient/physician visits.

*Providing academic connections...*
HCHD provides academic teaching facilities for the faculty and residents of Baylor College of Medicine and the University of Texas Health Science Center – Houston. These academic affiliations mean HCHD patients have access to the latest breakthroughs in medical technology and specialized treatment techniques.

*World-class, acute-care facilities...*
HCHD's two major hospitals, Ben Taub General Hospital and Lyndon B. Johnson General Hospital, are recognized for their world-class medical staffs and high level of acute specialty care. In fact, during the 1990s, HCHD facilities were twice named to the Top 100 Hospitals by Modern Healthcare.

*Ben Taub General Hospital* is a 588-bed facility, and is home to one of the nation's top trauma centers. Approximately 80 percent of Ben Taub's inpatients are admitted as emergencies. In 2002, Ben Taub's Trauma Center handled more than 100,000 emergency patient visits. Ben Taub had more than 24,000 adult and pediatric admissions in 2002 and more than 159,000 specialty clinic visits.

*Lyndon Baines Johnson (LBJ) General Hospital* is a 324-bed facility, featuring state-of-the-art equipment and a reputation for excellence in gynecology, obstetrics and neonatal intensive care, and other specialty areas. LBJ's level III trauma center is the county's only emergency care facility in the northeastern quadrant of Harris County—an area that lacked any sophisticated health care delivery system prior to LBJ's arrival. In 2002, LBJ had more than 81,600 emergency center visits, 91,500 outpatient clinic visits and more than 14,300 inpatient admissions.

*HCHD in the community...*

The Harris County Hospital District reaches beyond its acute-care facilities and into the community. **HCHD's Community Health Program (CHP)** is one of the nation's first public health care efforts directed toward community primary care. In 2002, the program had more than 520,000 patient visits to its network of 11 community health centers, six school-based clinics and dental center. While touching many people, HCHD's primary-care network accounts for only 11 percent of the district's annual operating budget.

HCHD's community health centers are strategically located in neighborhoods throughout Harris County to help alleviate transportation concerns for many patients. The 11 HCHD primary-care locations are: **Acres Home Health Center**, 818 Ringold Street; **Aldine Health Center**, 4755 Aldine Mail Route; **Baytown Health Center**, 1602 Garth Road; **Casa de Amigos Health Center**, 1615 North Main Street; **E. A. "Squatty" Lyons Health Center**, 1712 First Street in Humble; **Martin Luther King Jr. Health Center**, 3601 North MacGregor Way; **Northwest Health Center**, 1100 West 34th Street; **People's Health Center**, 6630 DeMoss Street; **Gulfgate Health Center**, 7550 Office City Drive; **Settegast Health Center**, 9105 North Wayside Drive; and **Strawberry Health Center**, 927 E. Shaw Road in Pasadena.

*Serving Harris County's special needs populations...*

HCHD offers two facilities dedicated to delivering high quality medical care to the county's special needs populations. Quentin Mease Community Hospital and Thomas Street Clinic illustrate HCHD's continued dedication to providing for the community's spectrum of medical needs.

***Quentin Mease Community Hospital*** is HCHD's 48-bed geriatric and inpatient physical rehabilitation care facility. Patients suffering spinal cord injuries, traumatic falls or violence-related injuries work to regain mobility and life skills through the innovative programs offered at Quentin Mease. Its location on South MacGregor is adjacent to the city's MacGregor Parkway green space along Brays Bayou and is convenient to Hermann Park and the University of Houston.

***Thomas Street Clinic*** opened its doors in 1989 as the nation's first freestanding HIV/AIDS treatment facility. Approximately 60 percent of Harris County's AIDS patients are treated at Thomas Street Clinic. In addition to a full-range of medical services, Thomas Street Clinic provides patients with easy access to a variety of counseling, housing and job placement assistance services. Childcare is also provided to patient families through a new federally funded grant program.