Attachment – A
Request for Charity Care Assistance

Dear Patient and Family:

City of Houston is committed to provide Charity Care Assistance (CCA) for Emergency Medical Services (EMS) transportation to the residents of Houston, Texas.

Our Charity Care Assistance:
Patients who are unable to pay for all or part of their EMS transportation, may apply for Charity Care assistance by completing and returning the attached form within 30 days from first invoice date. Patients and families who have income less than or equal to 250% of the Federal Poverty Guidelines (FPL) may qualify for Charity care depending on their family size and income.

To view our Charity Care assistance policy and guidelines, please click on the link below or go to City's website:
https://www.houstontx.gov/finance/acct_receivable.html

What does Charity Care cover? Charity Care covers charges related to EMS transportation provided by City of Houston, depending upon your eligibility.

If you have questions or need help completing this application: Please refer to link below for policy information or contact us via phone numbers provided below.

https://www.houstontx.gov/finance/acct_receivable.html

877-659-0481(English) and 877-659-0482(Spanish) Monday - Friday 7:00am to 4:00pm (CST)

For your application to be processed smoothly without delay, the following information must be provided:

- □ Provide number of family members in your household (includes birth related, marriage, or adoption).
- □ Family monthly gross monthly income.
- □ Sign and date Charity Care assistance form.

Along with your application, you must provide one of the following documents:

- □ A "W-2" withholding statement.
- □ 3 months of most current pay stubs.
- □ Most recent income tax return.
- □ Approval/denial of eligibility for Medicaid and/or state-funded medical assistance.
- □ Proof of unemployment.

Note: If any information requested does apply please mark "not applicable" or "NA."

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Mail completed application with all documentation to the address below:
City of Houston EMS – Charity Care Assistance Program
P. O. Box: 4945
Houston, Texas 77210

To submit your completed application in person: Please bring the application along with the supporting documents to the address below:
Accounts Receivable Group, Finance Department
611 Walker St. 10th Floor
Houston, Texas 77002

Note: Either you chose to mail in the application or submit it in person be sure to keep a copy of the application and all submitted supporting documents.

We will notify you of the final determination of eligibility and appeal rights (if applicable) within 15 calendar days of receiving a completed Charity Care assistance application and all required supporting documents.

By submitting a Charity Care assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly!
You may receive bills until we receive your information.

Charity Care Assistance Application Form – Confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION
Has the Patient applied for Charity Care Before? □ **Yes** □ **No** If yes date applied: _____
Has the patient applied for Medicaid? □ **Yes** □ **No** *May be required to apply before being considered for Charity care assistance*
Does the patient have any other assistance from State or County (e.g. Gold card)? □ **Yes** □ **No**
Is the patient currently homeless? □ **Yes** □ **No**
Is the patient's EMS transport related to a car accident or work injury? □ **Yes** □ **No**

PLEASE NOTE

- We cannot guarantee that you will qualify for Charity Care assistance.
- When we are reviewing your completed application, we may ask for additional information.
- We will send you a notification within 15 calendar days after receiving your complete application.

PATIENT AND APPLICANT INFORMATION			
Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify_____)	Birth Date		Social Security Number (optional*)
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*)
Mailing Address City State Zip Code			Main contact number(s)_____ ( )_____ ( ) _____ Email Address:

Employment status of person responsible for paying bill

□ **Employed** (date of hire:_____) □ **Unemployed** (how long unemployed:_____)

□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

FAMILY INFORMATION

Provide number of family members in your household (related by birth, marriage, and adoption).

FAMILY SIZE_____

Charity Care Assistance Application Form – confidential

INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

Family's gross income verification is required to determine Charity Care assistance. Please provide proof for every identified source of income. Below is the list of documents for proof of income.

Documents for proof of income:

- A "W-2" withholding statement.
- 3 months of current pay stubs.
- Most recent income tax transcripts.
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance.
- Proof of unemployment.

If you have no proof of income or no income, please attach an additional page with an explanation.

ADDITIONAL INFORMATION

Please attach any additional information regarding your current financial situation that you would like to inform us (i.e. financial hardship, seasonal, temporary income, or personal loss).

PATIENT AGREEMENT

I understand that City of Houston or it's designee may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for Charity Care assistance.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of Charity Care assistance, and I will be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date