



**ST. MARK'S**  
MEDICAL CENTER

One St. Mark's Place - La Grange, Texas 78945  
Phone: 979-242-2200

**APPLICATION FOR  
MEDICAL/FINANCIAL ASSISTANCE**

Name: \_\_\_\_\_  
(Please Print In Ink) LAST FIRST M.I.

Address: \_\_\_\_\_  
STREET CITY STATE ZIP CODE

Social Security Number Date of Birth Home Phone #

Employer Address City State Zip Code Phone #

**Other Family Member Employers:**

Employer Address City State Zip Code Phone #

Employer Address City State Zip Code Phone #

Family Members (Living At Same Address)	Name: First & Last	Relationship	Age
Head of Household	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Type of Uncompensated Service Requested:  Medical Treatment  Surgical Treatment  
 Previous Accounts  Other

**A. LIST ANNUAL FAMILY INCOME BY FOLLOWING CATEGORIES:**

Wages	_____	Public Assist, (Food Stamps, Welfare, SSI)	_____
Social Security	_____	Farm or Self Employment	_____
Unemployment	_____	Child Support	_____
Workers Compensation	_____	Alimony	_____
Strike Benefits	_____	Savings, Dividends, & Interest	_____
Pensions	_____	Military Family Allotments	_____
Rental Property	_____	Other	_____

**TOTAL FAMILY INCOME FOR THE LAST 12 MONTHS:** \_\_\_\_\_ MUST attach most recent completed tax return (1040 or 1040A), or explanation why not attached:

**SEE REVERSE SIDE FOR ADDITIONAL INFORMATION**



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### B. MEDICAL EXPENSES:

LIST ALL MEDICAL BILLS OWED AFTER INSURANCE, MEDICARE AND MEDICAID HAVE PAID.

**NAME OF BILLING FACILITY**

**BALANCE DUE**

#### HOSPITALS:

_____	_____
_____	_____
_____	_____

#### PHYSICIANS: (Includes Anesthesiologist, Radiologist, or Pathologist)

_____	_____
_____	_____
_____	_____

#### PHARMACIES:

_____	_____
_____	_____
_____	_____

#### AMBULANCE:

_____	_____
_____	_____
_____	_____

**TOTAL OF ALL MEDICAL EXPENSES:**

\_\_\_\_\_

I certify that the above information is true and accurate to the best of my knowledge.  
Falsification will result in denial of medical/financial assistance.

\_\_\_\_\_  
**Date of Request**

\_\_\_\_\_  
**Applicant's Signature**

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### FOR HOSPITAL USE ONLY

DATE APPLICATION RECEIVED: \_\_\_\_\_

INCOME VERIFIED: \_\_ YES \_\_ NO

\_\_\_ THE APPLICATION IS APPROVED FOR UNCOMPENSATED SERVICES IN THE AMOUNT OF \$ \_\_\_\_\_.

\_\_\_ THE APPLICATION IS DENIED FOR THE FOLLOWING REASON(S) \_\_\_\_\_  
\_\_\_\_\_

DATE OF DETERMINATION: \_\_\_\_\_ DETERMINATION PROCESSED BY: \_\_\_\_\_

DATE APPLICANT NOTIFIED: \_\_\_\_\_