CRAYON CARE
TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN

Dear Patient Family,

Thank you for choosing Texas Scottish Rite Hospital for Children as your care provider. Our mission is to provide premiere health care services to our patients regardless of the family's ability to pay. To support our mission, the Hospital has a Financial Assistance/Charity Care Program designed to help families ease the burden of medical expenses according to their financial needs.

The enclosed form applies to all families regardless of income levels and insurance types. You may qualify for care at no charge or at a significantly discounted rate.

Regardless of your current insurance (Blue Cross Blue Shield, Aetna, Cigna, etc.) please take the time to fill out this application so that we may better serve you. If you have any questions regarding this form please feel free to call 214-559-8630 and a Family Services Counselor will be happy to provide more details about our Family Assistance/Charity Care Program, answer any questions you may have, or assist you in any of your needs.

Thank you again for choosing Texas Scottish Rite Hospital for Children and please take a few minutes now to fill out the attached form.

Patient ID Number: _____

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## Financial Assistance/Charity Care Application

Patient Name: _____ DOB: _____ Sex: Male / Female

Telephone Number: _____ SSN: _____

Address: _____ County: _____
Street / City / State / Zip Code

| Caregiver/ Guardian Information | Caregiver / Guardian Information |
|---|---|
| Name: _____ DOB: _____ | Name: _____ DOB: _____ |
| Relationship to Patient: _____ | Relationship to Patient: _____ |
| Address: _____ Street / City / State / Zip Code | Address: _____ Street / City / State / Zip Code |
| SSN: _____ | SSN: _____ |
| Phone: _____ | Phone: _____ |
| Employer: _____ Name / Street / City / State / Zip Code | Employer: _____ Name / Street / City / State / Zip Code |

**Patient's Siblings in the Same Household**

| Name | DOB | Age | Sex | Also a TSRHC Patient (seen in last 12 Months) |
|---|---|---|---|---|
| | | | | ❑ Yes ❑ No |
| | | | | ❑ Yes ❑ No |
| | | | | ❑ Yes ❑ No |
| | | | | ❑ Yes ❑ No |
| | | | | ❑ Yes ❑ No |
| | | | | ❑ Yes ❑ No |

Marital Status of Caregivers: ❑ Married ❑Divorced ❑ Separated ❑ Single ❑ Widowed

What insurance(s) (if any) does the patient currently have?

❑ None ❑ Medicaid ❑ CHIP ❑ Commercial Insurance: _____ ❑Other : _____

Policy Number: _____ Group Number: _____

Who is listed as the subscriber on the patient's insurance? _____

### Eligibility Information

**Please provide the income for each of the following persons in your household (if applicable).**

**Circle one**

Patient $ _____Hr/ Wk /2xMonth /Bi-weekly /Year
Patient's Caregiver / Guarantor $_____ Hr /Wk /2xMonth /Bi-weekly /Year
Patient's Caregiver/Guarantor $ _____Hr /Wk/2xMonth /Bi-weekly /Year
Other $ _____Hr /Wk /2xMonth /Bi-weekly /Year

**Family Gross Income***: $_____

* Gross Income is the sum of the gross income of the patient, patient's mother, patient's father and/or other responsible party.

**Unreimbursed Medical Expenses*:** $_____

*These are the annualized and unreimbursed costs incurred by the family and include bills for services provided by the Hospital and other unreimbursed medical expenses.

**Number of Family Members living in household*:** _____

*This number is to include the patient, patient's mother, patient's father, dependents of the patient's mother and dependents of the patient's father.

**Income Verification:** **Provide documentation that reflects total household wages or proof of participation in a government assistance program.**

**Financial Assistance/Charity Care Application**

Please initial below:

_____ I/we declare that the answers I/we have given on this application are true and correct to the best of my/our knowledge.

_____ I/we agree to tell the Hospital as soon as possible, if there are any changes in the information provided in this application.

_____ I/we understand that the hospital is required by law to keep any information I/we provide confidential.

_____ I/we further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the Hospital from proceeds of any litigation or settlement resulting from such act.

_____ I/we understand that if I/we do not qualify for uncompensated services, I/we will be personally liable for the charges of the services rendered by Texas Scottish Rite Hospital and that I/we may appeal decision in writing with additional documentation.

If unable to provide proof of income, please explain why:

_____

_____

_____

I/we ask Texas Scottish Rite Hospital for Children (TSRHC) to determine if I/we are eligible for help in paying for my/our child's bill. I/we understand that I/we need to give certain information for this to be done. I/we also understand that TSRHC or its agents may check these facts for accuracy and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I am(we are) aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance. I /we understand that filling out this form does not guarantee that I/we will receive this help. If I am (we are) not eligible for uncompensated services, I am (we are) responsible for my/our child's hospital bill.

Signature of Caregiver/Guardian: _____ Date: _____

Signature of Caregiver/Guardian: _____ Date: _____

**Remember to submit: Income verification & if applicable, proof of 1% of your annual gross income in medical expenses for the family from the past 12 months.**

## FOR OFFICE USE ONLY

☐ Family qualifies for a discount of _____% on all Hospital Charges; provided, however, that the amount due after such discount will in all cases be limited to 1% of the family's gross income. The amount due, after application of the discount, is: $_____).

☐ Some portions of this application were completed by a TSRHC staff member. Those areas have been identified by the staff member's initials.

**Printed Name:** _____

**Signature:** _____ **Date:** _____

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# Financial Assistance Check List

- Complete financial assistance application _____
- Provide household income documentation for each income source (if applicable) _____
- Household is defined in this table based on the child's insurance

| CHILD'S INSURANCE | DEFINITION OF "HOUSEHOLD" |
|---|---|
| Commercial Insurance (Blue Cross / Blue Shield, Aetna, United, Cigna, etc…) | Guarantor's Household |
| Medicaid or other state funding | Household where the child lives |
| Uninsured | Household of the person who claims the child on annual tax return |

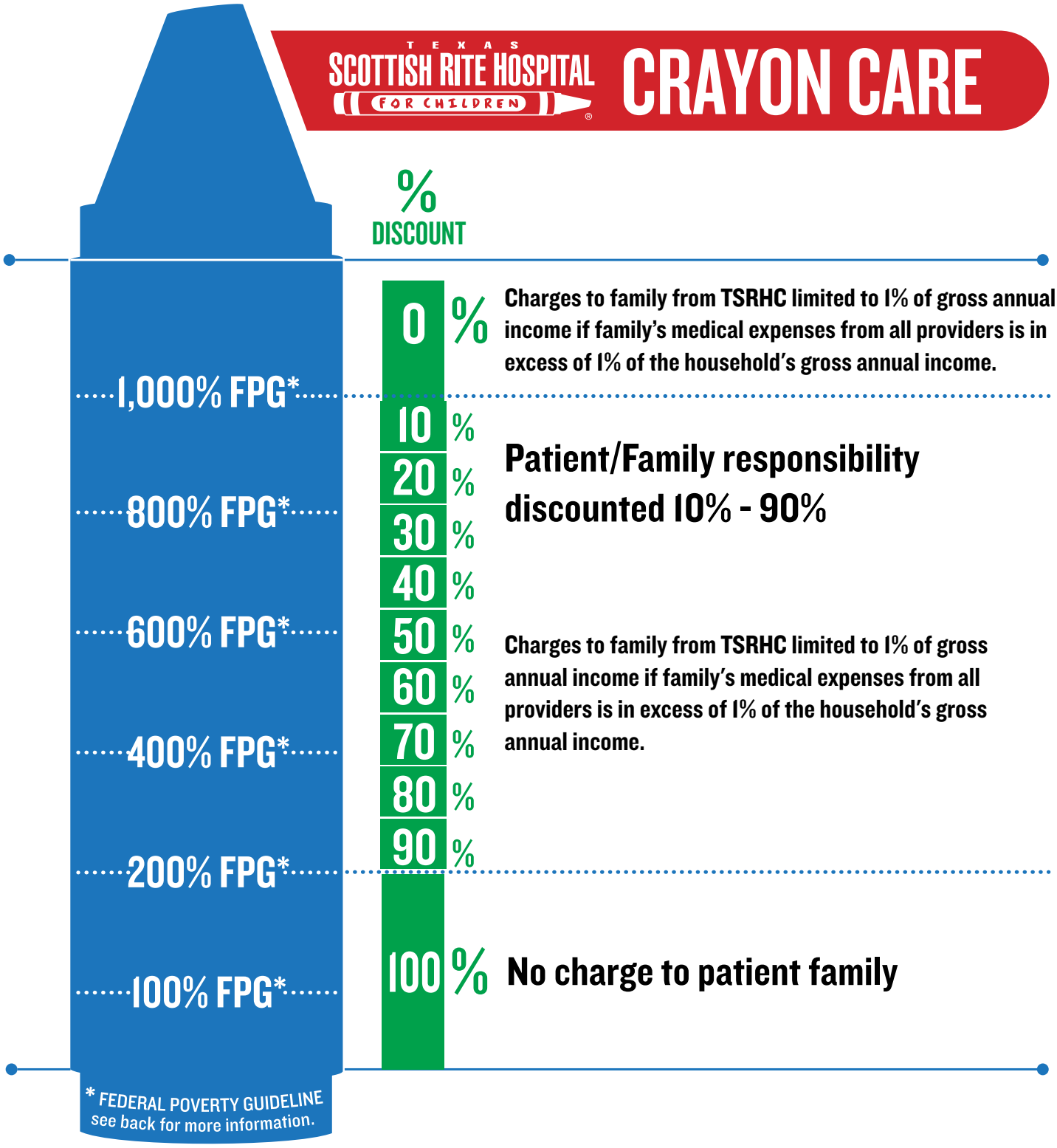
  - o Most current tax statement or pay check stub
  - o Proof of Social Security payment or workers' compensation
  - o Unemployment insurance payment notice; unemployment compensation determination letter; or other appropriate indicators of the family's reported income
  - o Documentation showing current participation in a public benefit program such as Medicaid; County Indigent Health Care Program; TANF; Food Stamps: WIC; TexCare Partnership; or other similar indigency-related programs

- Provide proof of 1% of your annual gross income in medical expenses for the family from the past 12 months _____
- Include a copy of your current health insurance card(s) _____
- Stamp and mail financial assistance application to the following address: OR fax it to the fax number below: _____

  - o Texas Scottish Rite Hospital for Children
    Attn: Family Service Counselors
    2222 Welborn Street; Dallas, TX 75219-3993
    FAX:214-443-7331
    EMAIL: FamilyServicesCounselors@tsrh.org

If you have any questions about your account, please call our Family Service Counselors at 214-559-8630

# TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN CRAYON CARE




**0 %** Charges to family from TSRHC limited to 1% of gross annual income if family's medical expenses from all providers is in excess of 1% of the household's gross annual income.

**10 % – 90%** Patient/Family responsibility discounted 10% - 90%

Charges to family from TSRHC limited to 1% of gross annual income if family's medical expenses from all providers is in excess of 1% of the household's gross annual income.

**100 %** No charge to patient family

## APPLICATION PROCESS

- ☑ Complete application
- ☑ Provide proof of household income and proof of medical expenses for the family from the past 12 months
- ☑ Proof of enrollment in Government Assistance Program (Medicaid, CHIP, Food Stamps, WIC, etc.) if applicable

## CONTACT INFO

FOR FAMILY SERVICES COUNSELORS

DALLAS CAMPUS
**214-559-8630**

FRISCO CAMPUS
**469-515-7191**

TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN CRAYON CARE

# CRAYON CARE QUALIFICATION AND DISCOUNT SCALES

2019 Federal Poverty Guidelines as established by the Department of Health & Human Services
$21,330 Federal Poverty Limit for a household of three dependents

| Household Size | | 3 or less |
|---|---|---|
| Income Range | | Discount |
| $0 | $42,660 | 100% |
| $42,661 | $63,990 | 90% |
| $63,991 | $85,320 | 80% |
| $85,321 | $106,650 | 70% |
| $106,651 | $127,980 | 60% |
| $127,981 | $149,310 | 50% |
| $149,311 | $170,640 | 40% |
| $170,641 | $191,970 | 30% |
| $191,971 | $202,635 | 20% |
| $202,636 | $213,300 | 10% |
| $213,301 | and up | 0% |

| Household Size | | 4 |
|---|---|---|
| Income Range | | Discount |
| $0 | $51,500 | 100% |
| $51,501 | $77,250 | 90% |
| $77,251 | $103,000 | 80% |
| $103,001 | $128,750 | 70% |
| $128,751 | $154,500 | 60% |
| $154,501 | $180,250 | 50% |
| $180,251 | $206,000 | 40% |
| $206,001 | $231,750 | 30% |
| $231,751 | $244,625 | 20% |
| $244,626 | $257,500 | 10% |
| $257,501 | and up | 0% |

| Household Size | | 5 |
|---|---|---|
| Income Range | | Discount |
| $0 | $60,340 | 100% |
| $60,341 | $90,510 | 90% |
| $90,511 | $120,680 | 80% |
| $120,681 | $150,850 | 70% |
| $150,851 | $181,020 | 60% |
| $181,021 | $211,190 | 50% |
| $211,191 | $241,360 | 40% |
| $241,361 | $271,530 | 30% |
| $271,531 | $286,615 | 20% |
| $286,616 | $301,700 | 10% |
| $301,701 | and up | 0% |

| Household Size | | 6 |
|---|---|---|
| Income Range | | Discount |
| $0 | $69,180 | 100% |
| $69,181 | $103,770 | 90% |
| $103,771 | $138,360 | 80% |
| $138,361 | $172,950 | 70% |
| $172,951 | $207,540 | 60% |
| $207,541 | $242,130 | 50% |
| $242,131 | $276,720 | 40% |
| $276,721 | $311,310 | 30% |
| $311,311 | $328,605 | 20% |
| $328,606 | $345,900 | 10% |
| $345,901 | and up | 0% |

| Household Size | | 7 |
|---|---|---|
| Income Range | | Discount |
| $0 | $78,020 | 100% |
| $78,021 | $117,030 | 90% |
| $117,031 | $156,040 | 80% |
| $156,041 | $195,050 | 70% |
| $195,051 | $234,060 | 60% |
| $234,061 | $273,070 | 50% |
| $273,071 | $312,080 | 40% |
| $312,081 | $351,090 | 30% |
| $351,091 | $370,595 | 20% |
| $370,596 | $390,100 | 10% |
| $390,101 | and up | 0% |

| Household Size | | 8 |
|---|---|---|
| Income Range | | Discount |
| $0 | $86,860 | 100% |
| $86,861 | $130,290 | 90% |
| $130,291 | $173,720 | 80% |
| $173,721 | $217,150 | 70% |
| $217,151 | $260,580 | 60% |
| $260,581 | $304,010 | 50% |
| $304,011 | $347,440 | 40% |
| $347,441 | $390,870 | 30% |
| $390,871 | $412,585 | 20% |
| $412,586 | $434,300 | 10% |
| $434,301 | and up | 0% |

| Household Size | | 9 |
|---|---|---|
| Income Range | | Discount |
| $0 | $95,700 | 100% |
| $95,701 | $143,550 | 90% |
| $143,551 | $191,400 | 80% |
| $191,401 | $239,250 | 70% |
| $239,251 | $287,100 | 60% |
| $287,101 | $334,950 | 50% |
| $334,951 | $382,800 | 40% |
| $382,801 | $430,650 | 30% |
| $430,651 | $454,575 | 20% |
| $454,576 | $478,500 | 10% |
| $478,501 | and up | 0% |

| Household Size | | 10 |
|---|---|---|
| Income Range | | Discount |
| $0 | $104,540 | 100% |
| $104,541 | $156,810 | 90% |
| $156,811 | $209,080 | 80% |
| $209,081 | $261,350 | 70% |
| $261,351 | $313,620 | 60% |
| $313,621 | $365,890 | 50% |
| $365,891 | $418,160 | 40% |
| $418,161 | $470,430 | 30% |
| $470,431 | $496,565 | 20% |
| $496,566 | $522,700 | 10% |
| $522,701 | and up | 0% |

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