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: _____

CRAYON CARE
SCOTTISH RITE FOR CHILDREN

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:** _____

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

  - Most current tax statement or pay check stub
  - Proof of Social Security payment or workers' compensation
  - Unemployment insurance payment notice; unemployment compensation determination letter; or other appropriate indicators of the family's reported income
  - 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

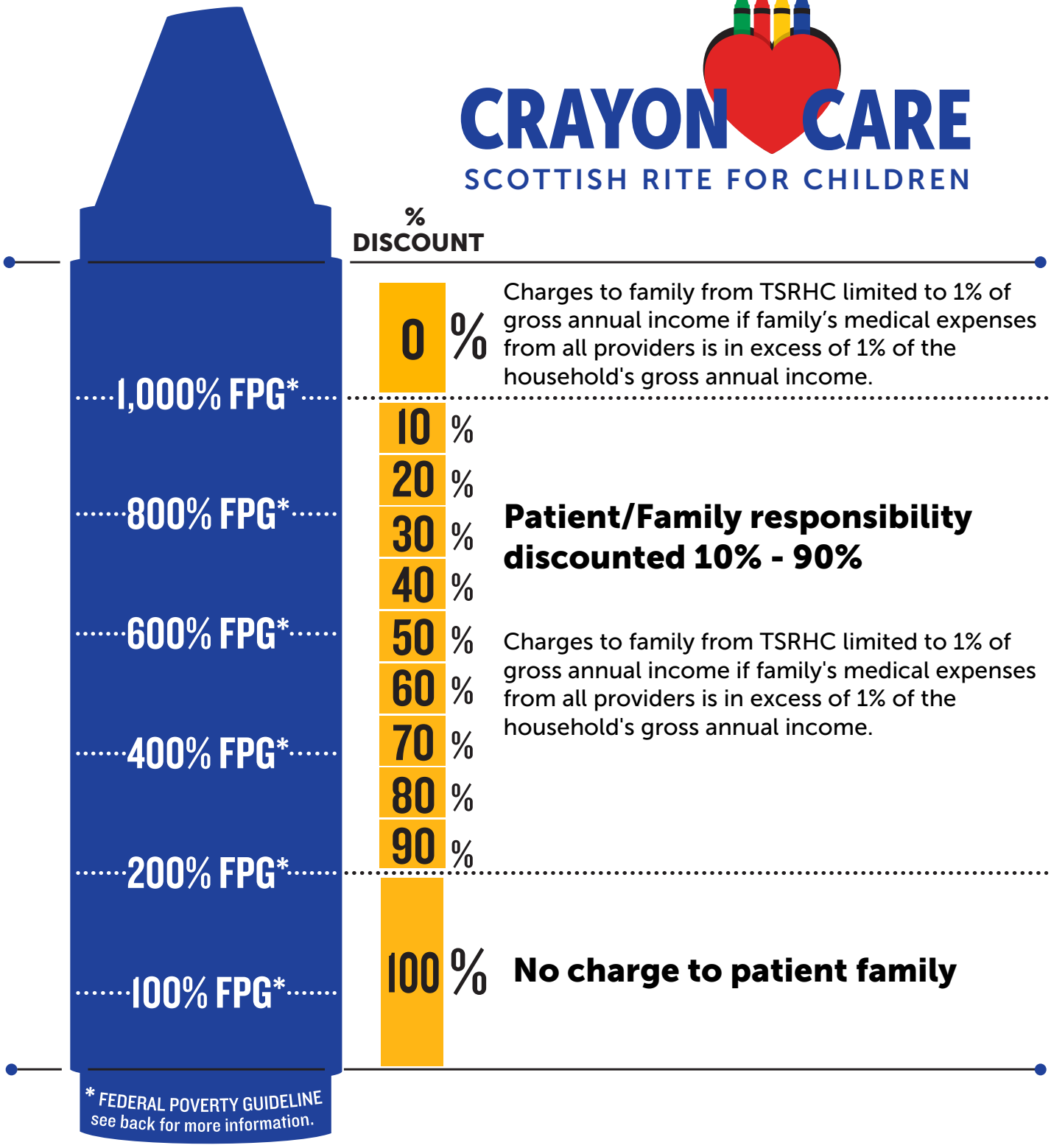
- Provide proof of 1% of your annual gross income in medical expenses for the family from the past 12 months _____
- Include a copy of your current health insurance card(s) _____
- Stamp and mail financial assistance application to the following address: OR fax it to the fax number below: _____

  - 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

CRAYON CARE

SCOTTISH RITE FOR CHILDREN



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

SCOTTISH RITE FOR CHILDREN CRAYON CARE

CRAYON CARE QUALIFICATION AND DISCOUNT SCALES

2020 Federal Poverty Guidelines as established by the Department of Health & Human Services
$21,720 Federal Poverty Limit for a household of three dependents

Household Size		3 or less
Income Range		Discount
$0	$43,440	100%
$43,441	$65,160	90%
$65,161	$86,880	80%
$86,881	$108,600	70%
$108,601	$130,320	60%
$130,321	$152,040	50%
$152,041	$173,760	40%
$173,761	$195,480	30%
$195,481	$206,340	20%
$206,341	$217,200	10%
$217,201	and up	0%

Household Size		4
Income Range		Discount
$0	$52,400	100%
$52,401	$78,600	90%
$78,601	$104,800	80%
$104,801	$131,000	70%
$131,001	$157,200	60%
$157,201	$183,400	50%
$183,401	$209,600	40%
$209,601	$235,800	30%
$235,801	$248,900	20%
$248,901	$262,000	10%
$262,001	and up	0%

Household Size		5
Income Range		Discount
$0	$61,360	100%
$61,361	$92,040	90%
$92,041	$122,720	80%
$122,721	$153,400	70%
$153,401	$184,080	60%
$184,081	$214,760	50%
$214,761	$245,440	40%
$245,441	$276,120	30%
$276,121	$291,460	20%
$291,461	$306,800	10%
$306,801	and up	0%

Household Size		6
Income Range		Discount
$0	$70,320	100%
$70,321	$105,480	90%
$105,481	$140,640	80%
$140,641	$175,800	70%
$175,801	$210,960	60%
$210,961	$246,120	50%
$246,121	$281,280	40%
$281,281	$316,440	30%
$316,441	$334,020	20%
$334,021	$351,600	10%
$351,601	and up	0%

Household Size		7
Income Range		Discount
$0	$79,280	100%
$79,281	$118,920	90%
$118,921	$158,560	80%
$158,561	$198,200	70%
$198,201	$237,840	60%
$237,841	$277,480	50%
$277,481	$317,120	40%
$317,121	$356,760	30%
$356,761	$376,580	20%
$376,581	$396,400	10%
$396,401	and up	0%

Household Size		8
Income Range		Discount
$0	$88,240	100%
$88,241	$132,360	90%
$132,361	$176,480	80%
$176,481	$220,600	70%
$220,601	$264,720	60%
$264,721	$308,840	50%
$308,841	$352,960	40%
$352,961	$397,080	30%
$397,081	$419,140	20%
$419,141	$441,200	10%
$441,201	and up	0%

Household Size		9
Income Range		Discount
$0	$97,200	100%
$97,201	$145,800	90%
$145,801	$194,400	80%
$194,401	$243,000	70%
$243,001	$291,600	60%
$291,601	$340,200	50%
$340,201	$388,800	40%
$388,801	$437,400	30%
$437,401	$461,700	20%
$461,701	$486,000	10%
$486,001	and up	0%

Household Size		10
Income Range		Discount
$0	$106,160	100%
$106,161	$159,240	90%
$159,241	$212,320	80%
$212,321	$265,400	70%
$265,401	$318,480	60%
$318,481	$371,560	50%
$371,561	$424,640	40%
$424,641	$477,720	30%
$477,721	$504,260	20%
$504,261	$530,800	10%
$530,801	and up	0%

SCOTTISH RITE FOR CHILDREN