



Bellville Medical Center
Financial Assistance Application
979-413-7350

Patient Account Number

Patient Name (Last, First, MI) Social Security Number

Patient's Residential Address City State Zip Code County

Marital Status: Married Single Widowed
Separated Divorced

Birth Date (Month/Date/Year) Telephone Number

Spouse's Name

Employed Yes No Spouse's Employer

Patient's Employer Spouse's Employer

Telephone # Telephone #

Are the BMC facilities you received services at the closest in network facilities to your primary residence? If no, were the closest facilities unable or unwilling to provide your care?

If unemployed, please include the previous employer's name and telephone number

A. Income: Please provide the income for each of the following persons in your household.
Patient, Spouse, Patient's Father, Patient's Mother
Includes checkboxes for Full Time, Part Time, and various work schedules, plus fields for Additional Income and Total Household Income.

B. Income Verification: Please provide verification (send only copies, no original documentation) for all sources of household income.
Includes checkboxes for Paycheck Remittance, Employer Verification, Governmental Assistance, IRS Form W-2, Tax Return, Social Security, Bank Statements, and Other.

C. Family Members: Please provide the total number of people in the patient's household.
(This number should only include the patient, patient's spouse, and the patient's dependents)

D. Assets and Other Resources:
Do you have any assets or other resources available to you?
Do you have medical insurance?
Do you have a Health Savings Account or Flexible Spending Account?

I understand Bellville Medical Center ("BMC") may verify the financial information contained in this Financial Assistance Application ("Application") in connection with BMC's evaluation of this Application...

I further understand that some physicians and providers may not be employees of BMC. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

Signature of Patient or Responsible Party Printed Name Date

For Hospital Use Only
Application information obtained by BMC Employee in person or over the phone, no patient signature required.
Notes Regarding Income Verification/Number in the Household:
Patient is part of community care program

Mail to:
Bellville Medical Center
P.O. Box 977
Bellville, TX 77418