WINGS OF Hope
WHEN LIFE MATTERS MOST

Wings of Hope Financial Assistance Application Form Instructions

This is an application for financial assistance from Wings of Hope.

Wings of Hope's Uninsured and Under-insured Program offers financial assistance to patients of Hummingbird Hospice and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. Each application is reviewed and approval is on a case by case basis.

What does financial assistance cover? Depending on your eligibility, medical financial assistance covers skilled nursing and aide care through Hummingbird Hospice staff, specialized medical equipment and/or medical supplies. Assistance may not cover all health care costs, including services provided by other organizations. Support for eligible family members includes assistance with rent/mortgage, utilities, home safety renovations, groceries, and/or funeral costs.

If you have questions or need help completing this application: Our financial assistance policies, information about the programs, and the application materials are available on our website or via phone. You may obtain help for any reason, including disability and language assistance. Translated written documents available upon request.
Here's how to contact us: https://www.wingsofhope-tx.com/faa
Customer Service Representatives at: 210-727-3513
Monday-Friday 9:00 am to 5:00 pm

In order for your application to be processed, you must:

- □ **Provide us information about your family**
  Fill in the number of family members in your household that you are financially responsible for.
- □ **Provide us information about your gross monthly income (income before taxes and deductions) to include social security amount**
- □ **Attach additional information if needed**
- □ **Sign and date the financial assistance form**

Note: **You do not have to provide a Social Security number to apply for financial assistance**. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail completed application with all documentation to: Wings of Hope 8420 Greenbrier Drive, San Antonio, Texas 78209. Be sure to keep a copy for yourself.

To submit your completed application in person: Hummingbird Hospice staff can accept and deliver applications to the office on your behalf.

We will notify you of the final determination of eligibility within 30 days of receiving a complete financial assistance application.

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

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

SCREENING INFORMATION

Do you need an interpreter? ☐ **Yes** ☐ **No** *If Yes, list preferred language:*

Has the patient applied for Medicaid? ☐ **Yes** ☐ **No**

Does the patient receive state public services such as TANF, Basic Food, or WIC? ☐ **Yes** ☐ **No**

Is the patient currently homeless? ☐ **Yes** ☐ **No**

Is the patient a veteran? ☐ **Yes** ☐ **No**

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 30 days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient First Name	Patient Last Name	Date of Birth

Address	Phone Number	Patient Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*

Main Point of Contact	Relationship to Patient	Email Address

Mailing Address
_____

_____
City State Zip Code

Main contact number(s)
( ) _____

( ) _____

Employment status of person responsible for paying bill
☐ **Employed** ☐ **Unemployed** (how long unemployed:_____)
☐ **Self-Employed** ☐ **Student** ☐ **Disabled** ☐ **Retired** ☐ **Other** (_____)

FAMILY INFORMATION

List family members in your household who you are financially responsible for, including yourself. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Age	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					☐ Yes / No ☐
					☐ Yes / No ☐
					☐ Yes / No ☐
					☐ Yes / No ☐

All adult family members' income must be disclosed. Sources of income include, for example:
- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support - Pension - Retirement account distributions - Other (*please explain*_____)

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You must provide information on your income. Income verification is required to determine financial assistance.

Examples of proof of income include:

- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance
- SSI documentation
- W-2 or most recent tax report

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

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage $_____
Insurance Premiums $_____
Other Debt/Expenses $_____ (*child support, loans, medications, other*)

Medical expenses $_____
Utilities $_____

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Wings of Hope may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

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

_____ _____
Signature of Person Applying Date