**EXHIBIT A**

MATAGORDA REGIONAL
MEDICAL CENTER

# CHARITY CARE QUESTIONNAIRE

| | | |
|---|---|---|
| Applicant's Name | Relationship to Patient | |
| Name of Patient | DOB | Status |
| Address | Phone# | |
| Previous Address | | |
| Spouse's Name | Spouse's DOB | |
| Your Social Security Number | | |
| Spouse's Social Security Number | | |
| Do you have medical insurance? | Yes: ( ) No: ( ) | |
| Have you applied for Indigent Care with the County? | Yes: ( ) No: ( ) | |
| Were you denied Indigent Care from the County? | Yes: ( ) No: ( ) | |
| Have you applied for Medicaid? | Yes: ( ) No: ( ) | |
| Were you denied access to Medicaid benefits? | Yes: ( ) No: ( ) | |
| Have you applied for benefits with the Social Security Administration? | Yes: ( ) No: ( ) | |
| Were you denied benefits by the Social Security Administration? | Yes: ( ) No: ( ) | |
| Have you applied for Supplemental Security Income? | Yes: ( ) No: ( ) | |
| Were you denied Supplement Security Income benefits? | Yes: ( ) No: ( ) | |
| Do you qualify for or participate in any of the following financial assistance programs, including but not limited to those listed below:<br>• State-funded prescription programs;<br>• Homeless or received care from a homeless clinic;<br>• Participation in Women, Infants and Children programs (WIC);<br>• Food stamp eligibility;<br>• Subsidized school lunch program eligibility;<br>• Low income assistance/subsidized financial assistance for housing at a current valid address | Yes: ( ) No: ( ) | |

**Assets**

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|---|---|---|---|
| Home: Rent: ( ) Buy: ( ) Own: ( ) | | | Monthly payment: $ |
| Auto: Year | Make | Model | Monthly payment: $ |
| Provide copies of all medical bills in or out of Wharton County | | | Total amount: $ |