



TEXAS
Health and Human
Services

Date

Eligibility Worker

Office Address and Telephone No.

REQUEST FOR PATIENT TRUST FUND INFORMATION
(Please provide the following information and return this form in the envelope provided.)

Has _____ had a patient trust fund within the last six months?..... Yes No

If "**No**," please just sign the form at the bottom and return.

If "**Yes**," please provide the trust fund balance as of 12:01 a.m. on the first day of the month(s) listed at the right:

| MONTH AND YEAR | AMOUNT |
|----------------|--------|
| | \$ |
| | \$ |
| | \$ |
| | \$ |

Also, please give the amount of interest earned for the month(s) listed here:

| MONTH AND YEAR | AMT. OF INTEREST |
|----------------|------------------|
| | \$ |
| | \$ |
| | \$ |
| | \$ |
| | \$ |
| | \$ |

VERIFIED BY: **X** _____
Signature Date

PLEASE RETURN THIS FORM IN THE ENVELOPE PROVIDED