BOB PIMENTEL IGRA RODEO CRISIS FUND APPLICATION

Name: Marcus Hood

Member Association: RRRA Member's IGRA Number: 8050

Address: 10656 Fishtrap Rd

City: Aubrey State/Province: TX Postal Code: 76227

Home Phone: ———

Work Phone: ———

Cell Phone: 972 358 0699

Social Security Number (U.S.): 460. 89. 4624

Social Security/Insurance # (Canada): ———

E-mail Address: Marcus.Hood595@gmail.com

Insured: ☒ YES ☐ NO

Name as it appears on Insurance Card:

First: Marcus Middle Initial: ____ Last: Hood

Name of Insurance Company: Aetna

Address: P.O. Box 14079 Lexington KY 40512-4079

City: Lexington State/Province: Ky Postal Code: 40512-4079

Office Phone: ———

Insurance Deductible: $ 3,200.00 / out of pocket 6,400

Gender: (Male) Female

Contact Information:

Rodeo Location: Phoenix AZ

Day: Saturday (Sunday)

Rodeo Director: Ron Trusley Phone #: _____

Arena Director: Tim Smith Phone #: _____

Treatment Level Provided:

- ☐ First Aid Only
- ☐ EMT/Paramedic
- ☐ Hospital Care and Released
- ☒ Hospital Care and Admitted (attach hospital report)

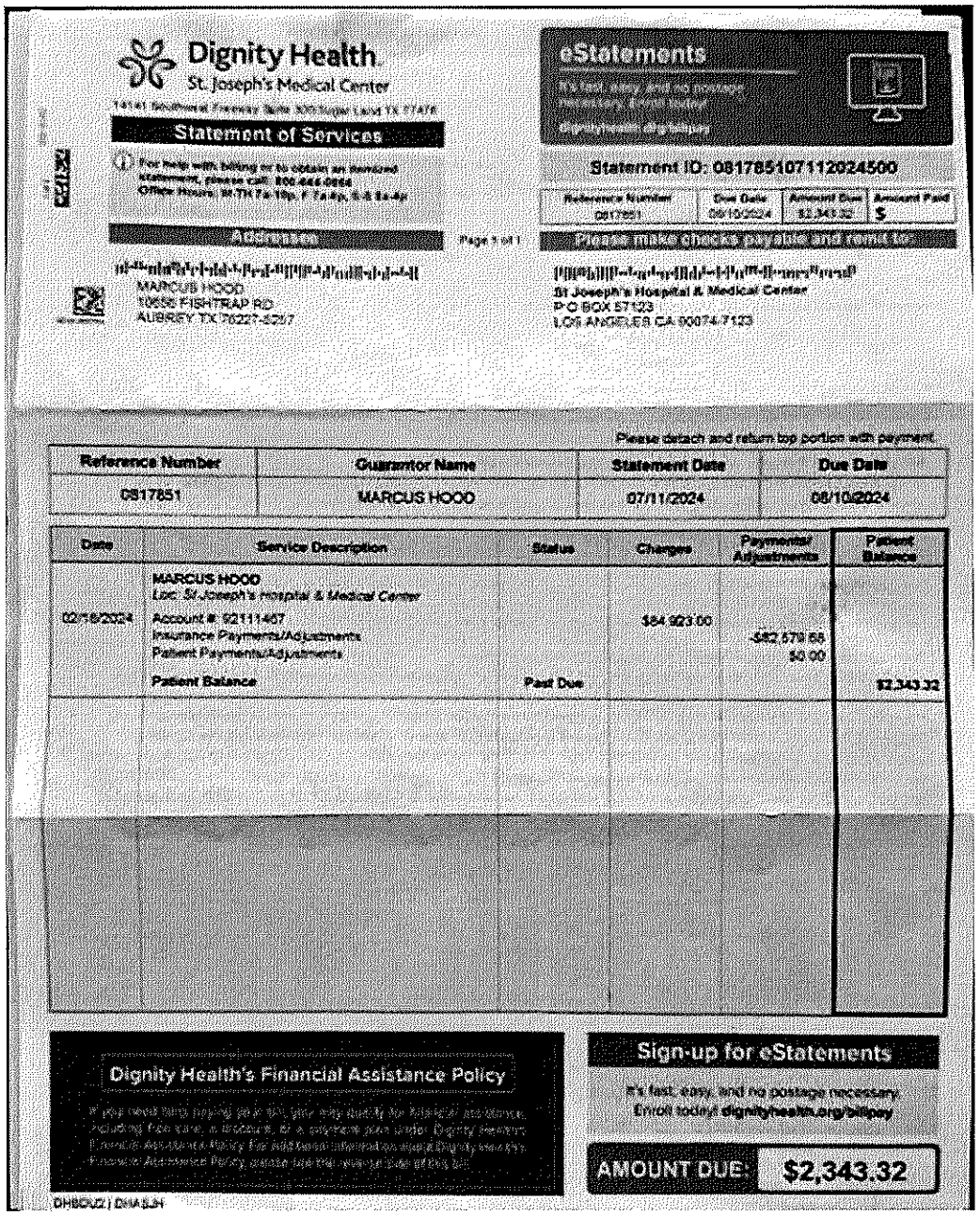
Provide a brief description of the injury if not admitted.

During Steer Riding I was bucked off, Landing on Right arm and broke the Humerus Bone. Spent 3 Days in hospital along with Surgery. Placed a Rod along with 3 screws 2 in shoulder 1 in the elbo.

Had Surgery again in July been in PT all year. End surgery the Remove hardware from 1st surgery redid entire arm and did bone graph.

Amount Requested: $ 500.00

Applicant's Signature: [signature]



Dignity Health
St. Joseph's Medical Center
14141 Southwest Freeway Suite 300 Sugar Land TX 77478

Statement of Services

For help with billing or to obtain an itemized statement, please call: 800.444.0884
Office Hours: M-TH 7a-10p, F 7a-4p, S & Su 4p

Address

MARCUS HOOD
10556 FISHTRAP RD
AUBREY TX 76227-5237

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eStatements

Statement ID: 0817851071120245000

Reference Number	Due Date	Amount Due	Amount Paid
0817851	08/10/2024	$2,343.32	$

Please make checks payable and remit to:

St Joseph's Hospital & Medical Center
P O BOX 57123
LOS ANGELES CA 90074-7123

Please detach and return top portion with payment.

Reference Number	Guarantor Name	Statement Date	Due Date
0817851	MARCUS HOOD	07/11/2024	08/10/2024

Date	Service Description	Status	Charges	Payments/ Adjustments	Patient Balance
	MARCUS HOOD *Loc: St Joseph's Hospital & Medical Center*				
02/16/2024	Account #: 92111467 Insurance Payments/Adjustments Patient Payments/Adjustments		$84,923.00	-$82,579.68 $0.00	
	Patient Balance	**Past Due**			**$2,343.32**

Dignity Health's Financial Assistance Policy

If you need help paying for your care, you may qualify for financial assistance, including free care, a discount, or a payment plan under Dignity Health's Financial Assistance Policy. For additional information about Dignity Health's Financial Assistance Policy, please see the "Patient Rights" section of this bill.

Sign-up for eStatements

It's fast, easy, and no postage necessary.
Enroll today! dignityhealth.org/billpay

AMOUNT DUE: $2,343.32

DHSOUZ | DHA SJH

Dignity Health.
St. Joseph's Medical Center

14141 Southwest Freeway Suite 300|Sugar Land TX 77478

Statement of Services

eStatements

It's fast, easy, and no postage necessary. Enroll today!

dignityhealth.org/billpay

Statement ID: 08178511108500

ⓘ **For help with billing or to obtain an itemized statement, please call: 800-644-0864**
Office Hours: M-TH 7a-10p, F 7a-6p, S-S 8a-4p

Reference Number	Due Date	Amount Due	Amount Paid
0817851	11/28/2024	$200.00	$

1 of 1

Addressee

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Please make checks payable and remit to:

MARCUS HOOD
10656 FISHTRAP RD
AUBREY TX 76227-5257

0021 007044

St Joseph's Hospital & Medical Center
P O BOX 57123
LOS ANGELES CA 90074-7123

Please detach and return top portion with payment.

Reference Number	Guarantor Name	Statement Date	Due Date
0817851	MARCUS HOOD	11/08/2024	11/28/2024

Date	Service Description	Status	Charges	Payments/ Adjustments	Patient Balance
	Payment Plan Balance Payment Plan Amount: $200.00 Payment Plan Amount Past Due: $0.00 **Payment Plan Amount Due**		$1,743.32		**$200.00**
	Thank you for choosing St Joseph's Hospital & Medical Center for your health care needs. This statement reflects charges for services you have received from us, including any payments that you and your insurance provider have made. **This notice is to remind you that your monthly payment of $200.00 to St Joseph's Hospital & Medical Center is due by 11/28/2024. Your payment plan may terminate if you fail to make the required monthly payment(s). If your financial situation has changed and you need to change the terms of this payment plan, please contact us at 800-644-0864 to discuss your options.**				

Dignity Health's Financial Assistance Policy

If you need help paying your bill, you may qualify for financial assistance, including free care, a discount, or a payment plan under Dignity Health's Financial Assistance Policy. For additional information about Dignity Health's Financial Assistance Policy, please see the reverse side of this bill.

Sign-up for eStatements

It's fast, easy, and no postage necessary.
Enroll today! **dignityhealth.org/billpay**

AMOUNT DUE: $200.00