Texas Health Hospital

Financial Assistance Application

Date:________________________ Guarantor Name: ____

Patient Name: ____ Date of Service: __________________

Hospital Account #____ Medical Record # _________________

Dear Patient:

Attached you will find the Texas Health Hospital Financial Assistance Application. Completion of this application will enable us to present your account for consideration of financial assistance for your hospital bill(s). **This is for your hospital charges only.**

We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential information. It will only be shared within Texas Health Resources on a need to know basis.

Please complete each item on the application. If you need additional space for any explanations, please utilize the back of the application.

Please provide the following information for consideration:

- Current month and two months prior pay stubs for household
- Copy of letter showing the amount you receive monthly in disability, workman's comp or unemployment
- Last three months bank statements proving any monthly income
- Most recently filed personal income tax return and current profit and loss statement (if applicable)
- Notarized letter of support - if do not have any income and being supported by someone else

Please complete the application and return it with the supporting documentation to:

Texas Hospital Financial Assistance Program

1401 E. Trinity Mills Rd., Carrollton, TX 75006

Without the above listed items, we may not be able to process your application

It is extremely important that you complete this application upon receipt and return it as soon as possible.

If you have difficulty completing this application or there is an area that is unclear, please call. Your cooperation is appreciated.

1401 E. Trinity Mills Rd
Carrollton, TX 75006
972-810-0700

Application for Financial Assistance - *Page 1*

Patient: *Last*____________________ *First*__________________________ *MI*________

Social Security #:________________ DOB:______________ Hospital Account #:______________

Married:__________ Single:________ Divorced:__________ Widowed:________ Separated:______

Do you have minor children (under 18)?	____Yes	____No
Do they live with you?	____Yes	____No
Are they your birth/legally adopted children?	____Yes	____No
Patient Employed?	____Yes	____No
Spouse Employed? Yes No	____Yes	____No
Do you have medical insurance?	____Yes	____No
Are you on disability? How long? ________________	____Yes	____No
Are you a veteran?	____Yes	____No

Family Members - (Living in the home)

Spouse: ________________________________

Child: ________________________________	Age ______
Child: ________________________________	Age ______
Child: ________________________________	Age ______
Child: ________________________________	Age ______

Income - (Monthly Amount)

	Gross	***Net***
Patient	$________	$________
Spouse	$________	$________
Dependants	$________	$________
Public Assistance	$________	$________
Food Stamps	$________	$________
Social Security	$________	$________
Unemployment	$________	$________
Strike Benefits	$________	$________
Worker's Compensation	$________	$________
Alimony	$________	$________
Child Support	$________	$________
Military Allotments	$________	$________
Pensions	$________	$ ________
Income from: CD's Rent, Dividends Interest	$________	$________
TOTAL	**$**________	**$**________

Expenses

Monthly Amount	
Mortgage/Rent	$________
Utilities	$________
Car Payments	$________
Food / Groceries	$________
Credit Cards	$________
Other (please specify)	
______________	$________
TOTAL	**$**________

Assets

Checking Account	$______________
Savings Account	$______________
CD's, IRA's	$______________
Other Investments (Stocks, bonds, etc.)	$______________
Properties/Land other than primary residence	$______________

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Name of Employer ______________________________ Spouse's Employer:______________________________

Telephone # Telephone #______________________________

Employer Address ______________________________ Employer Address______________________________

Occupation ______________________________ Occupation______________________________

Are you currently applying for Medicaid Benefits? _____Yes _____No

Have you applied for assistance thru your county hospital/indigent program? _____Yes _____No

Is your physician donating his/her services? _____Yes _____No

Are there any potentially liable third-parties responsible for your accident/injury/illness? _____Yes _____No

Is anyone assisting you with payment of your hospital bills? _____Yes _____No

_____Yes _____No

Who is assisting you? ______________________________

How much assistance are you receiving? ______________________________

List any other information you feel would be helpful to us in determining your eligibility for assistance in paying your hospital bill.

____

____

____

Expected earnings and/or funds you will receive during your time off due to your illness

(Sick leave, paid time off, short/long term disability income). $______________

Expected length of time you will be unable to work and/or earn wages: ______________

I understand that Texas Health Hospital may verify the financial information contained in this application in connection with the hospital's evaluation of this application, and hereby authorize the hospital to contact my employer to certify the information provided and to request reports from credit reporting agencies. I am aware that this information will be used to determine my eligibility for financial assistance and that the falsification of information in this application may result in denial of Financial Assistance care assistance. I also understand that any Financial Assistance approval may be completely or partially reversed in the event of a recovery from a third-party or other source.

I further understand that any Financial Assistance care I receive shall not be construed as a waiver by hospital of its hospital lien for reimbursement of any amount I owe and that any reimbursement I receive relating to this hospitalization must be sent to Texas Health Hospital.

______________________________ ______________

Signature of Person Making Request, If Patient Date

______________________________ ______________

Signature of Person Making Request, If Not Patient Relationship

______________________________ ______________

Patient's Address City State ZIP County Home Telephone Number