

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: _____ Age _____
 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 \$ _____



Application for Financial Assistance - Page 2

Name of Employer _____
Telephone # _____
Employer Address _____
Occupation _____

Spouse's Employer: _____
Telephone # _____
Employer Address _____
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
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

