



Dear Patient:

Attached you will find the Texas Health Center for Diagnostics and Surgery Financial Assistance Application. Completion of this application will enable us to present your account to the Financial Assistance Committee for consideration of financial assistance for your hospital bill. As a reminder, this application may only be reviewed by our facility due to privacy concerns.

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 the Texas Health Center for Diagnostics and Surgery and Texas Health Partners 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 copies of your most recent pay stub showing year to date for 2013. Also please provide a copy of your 2012 personal income tax return (top sheet only) and if self employed; a current copy of a profit and loss statement or copies of your bank statements for the current year. You can also attach copies of any outstanding medical bills that you and your family are receiving that are being billed to you for the patient portion for any medical provider (except dental). This can help you qualify in case your income/assets are over the guidelines.

It is extremely important that you complete this application upon receipt and return it as soon as possible. Upon completion, you may email it to Wend.Medrano@thcds.com, fax it to **972-403-2825** or mail it to the following address: **6020 West Parker Road, Plano, TX 75093 Attention: Wendy Medrano.**

If you have difficulty completing this application or there is an area which is unclear, please call 972-403-2832 or you may contact the verification representative that originally contacted you with your amount due.

Your cooperation is appreciated.



APPLICATION FOR FINANCIAL ASSISTANCE

Date: _____
Patient: _____
Account: _____

MEDICAL INSURANCE? YES / NO

INPATIENT / OUTPATIENT

IMPLANT COST:

DATE OF SERVICE:

ORDERING PHYSICIAN:

Patient Last Name: _____ First Name: _____

Social Security #: _____ Account #: _____

Marital Status: 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 or legally adopted children? Yes _____ No _____

Patient employed? Yes _____ No _____

Spouse employed? Yes _____ No _____

Do you have medical insurance? Yes _____ No _____

Are you on disability? Yes _____ No _____

If so, how long? Yes _____ No _____

Are you a Veteran? Yes _____ No _____

FAMILY MEMBERS

Spouse: _____

Child: _____ Age: _____

Child: _____ Age: _____

Child: _____ Age: _____

Child: _____ Age: _____

Child: _____ Age: _____

**** Children over the age of 18 must be full time students and/or counted as a deduction on your tax return****

INCOME (Monthly Amount):

Patient	\$	\$
Spouse	\$	\$
Dependents	\$	\$
Public Assistance	\$	\$
Food Stamps	\$	\$
Social Security	\$	\$
Unemployment	\$	\$

EXPENSES (Monthly Amount):

Rent/Mortgage	\$
Homeowner's Insurance	\$
Property Tax	\$
Electric	\$
Gas/Propane	\$
Water	\$
Telephone	\$

	<u>Total Owed</u>	<u>Monthly Payment</u>
Doctor(s)	\$	\$
Medicine(s)	\$	\$

Strike Benefits	\$	\$
Worker's	\$	\$
Alimony	\$	\$
Military Allotments	\$	\$
Pensions	\$	\$
Income from CDs, Rent, Dividends	\$	\$
TOTAL	<u>\$</u>	<u>\$</u>

Food	\$
Car Payment	\$
Car Insurance	\$
Gasoline	\$
Alimony/Child Support	\$
Child Care	\$
Clothing	\$
Charge Cards (Total per month)	\$
Loans	\$
Medical Insurance	\$
Life Insurance	\$
Other:	\$
TOTAL	<u>\$</u>

ASSETS:

Checking Account	\$	\$
Savings Account	\$	\$
CDs	\$	\$
IRAs	\$	\$
Investments (Stocks, Bonds)	\$	\$
Land/Property	\$	\$
Other	\$	\$
TOTAL	<u>\$</u>	<u>\$</u>

VEHICLES:

	<u>Make</u>	<u>Estimated Value</u>
Auto # 1		\$
Auto # 2		\$
Motorcycle		\$

MEDICAL BILLS: Table encompasses previous medical bills and expenses excluding this visit.
(Monthly Payment and Total Owed)

Hospital(s)	\$	\$
Other	\$	\$

EMPLOYMENT

INFORMATION:

Name of Applicant's Employer:
Telephone #:
Employer's Address: _____
Occupation:

Name of Spouse's Employer:
Telephone #:
Employer's Address: _____
Occupation:

Are you currently applying for Medicaid Benefits? Yes ____ No ____

Have you applied for assistance through your county hospital/indigent program?
Yes ____ No ____

Is your Physician donating his/her services?
Yes ____ No ____

Is there a potentially liable third-party responsible for your accident/injury/illness?
Yes ____ No ____

Is anyone assisting you with payment of your hospital bill(s)?
Yes ____ No ____

Who is assisting you? _____

How much assistance are you receiving? \$_____

Please list any other information you feel would be helpful to us in determining your eligibility for assistance in paying your hospital bill: _____

Please list expected earnings and/or funds you will receive during your time off due to your illness (i.e., sick leave, paid time-off, short- and/or long-term disability income, etc.): \$_____

Please list expected length of time you will be unable to work and/or earn wages: _____

STATEMENT:

I understand that **TEXAS HEALTH CENTER FOR DIAGNOSTICS AND SURGERY** may verify the financial information contained in 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 charity assistance, and that the falsification of information in this application may result in denial of charity care assistance. I also understand that any charity 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 charity care I receive shall not be construed as a waiver by the hospital of its' lien for reimbursement of its' full, billed charges, and that any reimbursement I receive relating to this hospitalization must be sent to **TEXAS HEALTH CENTER FOR DIAGNOSTICS AND SURGERY**.

Signature of Requestor (If Patient)

Date

Signature of Requestor (If NOT Patient)

Relationship

Date

Patient's Street Address

City, State, Zip

Home Phone Number

County of Residence

6020 West Parker Road · Plano, Texas 75093 · (972) 403-2700