Texas Health
Center for Diagnostics & Surgery
PLANO

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. 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 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 2014. Also please provide a copy of your 2013 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, please fax it to 214-619-0714 or mail it to the following address,
Attention Regina Terry
500 East Border Street #122
Arlington, Texas 76010

If you have difficulty completing this application or there is an area which is unclear, please call 214-619-4700 or you may contact the verification representative that originally contacted you with your amount due.

Your cooperation is appreciated.

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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):			**EXPENSES (Monthly Amount):**	
Patient	$	$	Rent/Mortgage	$
Spouse	$	$	Homeowner's Insurance	$

Dependents	$	$	Property Tax	$
Public Assistance	$	$	Electric	$
Food Stamps	$	$	Gas/Propane	$
Social Security	$	$	Water	$
Unemployment	$	$	Telephone	$
Strike Benefits	$	$	Food	$
Worker's	$	$	Car Payment	$
Alimony	$	$	Car Insurance	$
Military Allotments	$	$	Gasoline	$
Pensions	$	$	Alimony/Child Support	$
Income from CDs, Rent, Dividends	$	$	Child Care	$
			Clothing	$
TOTAL	$	$	Charge Cards (Total per month)	$
			Loans	$
ASSETS:			Medical Insurance	$
Checking Account	$	$	Life Insurance	$
Savings Account	$	$	Other:	$
CDs	$	$		$
IRAs	$	$	**TOTAL**	$

	Total Owed	Monthly Payment
Doctor(s)	$	$
Medicine(s)	$	$
Hospital(s)	$	$
Other	$	$

Investments (Stocks, Bonds)	$	$
Land/Property	$	$
Other	$	$
TOTAL	$	$

VEHICLES:	**Make**	**Estimated Value**
Auto # 1		$
Auto # 2		$
Motorcycle		$

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

EMPLOYMENT INFORMATION:

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

Street Address City, State, Zip

_____ _____

Home Phone Number County of Residence