Texas Health Resources℠

Arlington Memorial Hospital
Harris Methodist Hospitals
Presbyterian Hospitals

500 E Border Street #130
Arlington Texas 76010
682-236-3000 / 800-890-6034
THRFinancialassistance@texashealth.org

Date: _____ Guarantor Name: _____

Patient Name: _____ Date of Service: _____

Hospital Account #_____ Medical Record # _____

☒ Texas Health Allen	☐ Texas Health Denton	☐ Texas Health Prosper
☐ Texas Health Alliance	☐ Texas Health Frisco	☐ Texas Health Recovery & Wellness Center
☐ Texas Health Arlington Memorial	☐ Texas Health Fort Worth	☐ Texas Health Southwest Fort Worth
☐ Texas Health Azle	☐ Texas Health Heart & Vascular Hospital Arlington	☐ Texas Health Specialty Hospital
☐ Texas Health Burleson	☐ Texas Health HEB	☐ Texas Health Springwood
☐ Texas Health Cleburne	☐ Texas Health Kaufman	☐ Texas Health Stephenville
☐ Texas Health Dallas	☐ Texas Health Plano	☐ Texas Heath Urgent Care

Dear Patient:

Attached you will find the Texas Health Resources Financial Assistance Application. Completion of this application will enable us to present your account for consideration of financial assistance for your hospital or urgent care bill(s). This is for your hospital or urgent care 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 copies of your current month and two prior months pay stubs and/or proof of any other form of income for the household. If you do not receive check stubs, please provide copies of your bank statements showing your monthly deposits. If self-employed, please provide a copy of your most recently filed personal income tax return and a current profit and loss statement. Failure to provide the requested documentation can result in a denial for financial assistance consideration.

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.

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APPLICATION FOR FINANCIAL ASSISTANCE – Page 1

Patient Name: Last _____ First _____ MI _____

Social Security # _____ DOB: _____ Hospital Account #: _____

Married X Single _____ Divorced _____ Widowed _____ Separated _____

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

FAMILY MEMBERS – (Living in the home)

Spouse: _____
Child: _____ Age: _____
Child: _____ Age: _____
Child: _____ Age: _____
Child: _____ Age: _____

INCOME (Monthly Amount):

	Gross	Net
Patient	$0	$0
Spouse	$0	$0
Dependents	$0	$0
Public Assistance	$0	$0
Food Stamps	$0	$0
Social Security	$0	$0
Unemployment	$0	$0
Strike Benefits	$0	$0
Worker's Compensation	$0	$0
Alimony	$0	$0
Child Support	$0	$0
Military Allotments	$0	$0
Pensions	$0	$0
Income from: CD's Rent, Dividends Interest	$0	$0
TOTAL	$0	$0

Expenses	Monthly Amount
Mortgage/Rent	$ 0
Utilities	$ 0
Car Payments	$ 0
Food / Groceries	$ 0
Credit Cards	$ 0
Other (please specify) _____	$ 0
TOTAL	$ 0

ASSETS

Checking Account	$ 0
Savings Account	$ 0
CD's, IRA's	$ 0
Other Investments (Stocks, bonds, etc.)	$ 0
Properties/Land other than primary residence	$ 0

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APPLICATION FOR FINANCIAL ASSISTANCE – Page 2

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

Are you currently applying for Medicaid Benefits?	X	Yes		No
Have you applied for assistance thru your county hospital/indigent program?	X	Yes		No
Is your physician donating his/her services?	X	Yes		No
Are there any potentially liable third-parties responsible for your accident/injury/ illness?	X	Yes		No
Is anyone assisting you with payment of your hospital bills?	X	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). $0

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

I understand that Texas Health Resources 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 Resources.

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 _____