500 E Border Street #122
Arlington Texas 76010
682-236-1600 / 800-715-7210
customerservice@texashealthpartners.com

Date: 8/7/2021 Guarantor Name: Guarantor

Patient Name: First Last Date of Service: 8/7/2021

Hospital Account # 12345 Medical Record # 12345

☐ Texas Health Center for Diagnostics & Surgery Plano	☐ Texas Health Harris Methodist Hospital Southlake	☒ Texas Health Presbyterian Hospital Flower Mound
☐ Texas Health Presbyterian Hospital Rockwall	☐ Texas Institute for Surgery at Presbyterian Hospital of Dallas	

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 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 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 Last First First MI M

Social Security # 123456789 DOB: 6/2/1997 Hospital Account #: 12345

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?		Yes	X	No
Patient Employed?		Yes	X	No
Spouse Employed?		Yes	X	No
Do you have medical insurance?		Yes	X	No
Are you on disability? How long? 2 weeks	X	Yes		No
Are you a veteran?		Yes	X	No

FAMILY MEMBERS – (Living in the home)

Spouse: Spouse Name
Child: Child 1 Name Age: 1
Child: Child 2 Name Age: 2
Child: Child 3 Name Age: 3
Child: Child 4 Name Age: 4

INCOME (Monthly Amount):

	Gross	Net
Patient	$ 100	$ 200
Spouse	$ 300	$ 400
Dependants	$ 500	$ 600
Public Assistance	$ 700	$ 800
Food Stamps	$ 900	$ 1000
Social Security	$ 1100	$ 1200
Unemployment	$ 1300	$ 1400
Strike Benefits	$ 1500	$ 1600
Worker's Compensation	$ 1700	$ 1800
Alimony	$ 1900	$ 2000
Child Support	$ 2100	$ 2200
Military Allotments	$ 2300	$ 2400
Pensions	$ 2500	$ 2600
Income from: CD's Rent, Dividends Interest	$ 2700	$ 2800
TOTAL	$ 19600	$ 21000

Expenses	Monthly Amount
Mortgage/Rent	$ 2900
Utilities	$ 3000
Car Payments	$ 3100
Food / Groceries	$ 3200
Credit Cards	$ 3300
Other (please specify) 3400	$ 3500
TOTAL	$ 19000

ASSETS

Checking Account	$ 3600
Savings Account	$ 3700
CD's, IRA's	$ 3800
Other Investments (Stocks, bonds, etc.)	$ 3900
Properties/Land other than primary residence	$ 4000

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APPLICATION FOR FINANCIAL ASSISTANCE – Page 2

Name of Employer	My Emp	Spouse's Employer:	Spo Emp
Telephone #	123456789	Telephone #	1234567809
Employer Address	123 Street Ln	Employer Address	456 Lane Rd
Occupation	Job	Occupation	Other Job

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 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