

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

ate: Guarantor Name:			
Patient Name:	Date	e of Service:	
Hospital Account #	Med	lical 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		

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: <u>La</u>	st	First			MI
Social Security #		_ DOB:	Hospital Accour	nt #:	
Married	Single	Divorced	Widowed	Separate	ed
Do you have minor of Do they live with you Are they your birth/le Patient Employed? Spouse Employed? Do you have medica Are you on disability Are you a veteran?	? egally adopted ch l insurance? How long? -(Living in the h	ildren?	Yes	No No No No No No No	
Child:		Age:	-		
INCOME (Monthly A	mount): <u>Gross</u>	Net	Expens	200	Monthly Amount
Patient Spouse Dependents 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	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	\$	Mortgage, Utilities Car Paym Food / Gr	/Rent ents oceries	\$\$ \$\$ \$\$ \$\$ \$\$
TOTAL	\$	<u> </u>			
ASSETS Checking Account Savings Account CD's, IRA's Other Investments (S Properties/Land other		\$ c.) \$		<u></u>	



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APPLICATION FOR FINANCIAL ASSISTANCE - Page 2

Name of Employer	Spouse's Employer:					
Telephone #	Telephone # Employer Address					
Employer Address						
Occupation	Occupation	n				
Are you currently applying for Medica Have you applied for assistance thru Is your physician donating his/her ser	your county hospital/indigent program?	Yes Yes Yes	No No No			
Are there any potentially liable third-p illness?	parties responsible for your accident/injur	y/ Yes	 No			
Is anyone assisting you with paymen Who is assisting you? How much assistance are you rec	Yes	No				
List any other information you feel wou paying your hospital bill.	uld be helpful to us in determining your el	gibility for assistance in				
(Sick leave, paid time off, short/long te	•	r illness \$	_			
Expected length of time you will be una	able to work and/or earn wages:					
with the hospital's evaluation of this ap information provided and to request re to determine my eligibility for financial denial of Financial Assistance care ass	rces may verify the financial information of oplication, and hereby authorize the hospiports from credit reporting agencies. I arrassistance and that the falsification of infesistance. I also understand that any Final event of a recovery from a third-party or other than the state of the second s	tal to contact my employer to n aware that this information ormation in this application m ncial Assistance approval ma	certify the will be used ay result in			
	Assistance care I receive shall not be co amount I owe and that any reimburseme ses.					
Signature of Person Making Request,	If Patient	Date				
Signature of Person Making Request,	If Not Patient	Relationship				
Patient's Address City St	ate ZIP County	Home Telephone	Number			