Methodist
HOSPITAL FOR SURGERY

FINANCIAL ASSISTANCE APPLICATION

Please provide copies of the following information with your application. Failure to do so will result in a delay or possible denial of your application.

1. Proof of identity: current driver's license, DPS ID card, voter's registration card, alien registration card or temporary resident card.
2. Most recent checking, savings and credit union statement.
3. Verification of stock, bonds, notes or CD's.
4. At least four of your most recent check stubs or an employment verification form completed by your employer.
5. Award letters or verification of other income such as Social Security, SSI, unemployment, worker compensation, retirement and child support.
6. Rent receipts or mortgage receipts.
7. Car payment receipts.
8. Utilities receipts.
9. Any other monthly expense receipts (i.e. unpaid medical bills, prescription drug receipts, day care expenses, grocery, gas receipts, tuition, etc.)
10. Most recent tax return.

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PLEASE PRINT CLEARLY

Applicant's Name - Last	First	Middle	
Home Phone #	Cell phone #	Work phone #	
Mailing Address	City	State	Zip
Home address (if different from mailing)	City	State	Zip

☐ I need medical care and cannot pay for it	☐ I have medical bills that I cannot pay

Answer every question. Write 'NA' if the question does not apply. This application should be completed by, or for the applicant.

1. Fill in all blanks for everyone who lives with you, whether you consider them household members or not.

	Name			What kin to you	DOB	Sex	Married	In school	SS#
	Last	First	Middle			M/F	Y/N	Y/N	
1									
2									
3									
4									
5									
6									
7									
8									

2. Give your household's county and state of residence (where you make your home)

County	State

3. Does anyone who lives with you receive benefits from (check Yes or No for each type of program)

AFDS	SSI	Food stamps	SS	Medicaid	WIC
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

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4. Do you or anyone that lives with you have a job (including day work, babysitting, etc.) or any of you in training for a job? ☐ **Yes** ☐ **No** (If yes, fill out the blanks for each person who is in training, or is employed (including self–employment)

		# of hours per week		How often paid?					Gross pay (before deductions)
Give names of people who are WORKING or in TRAINING	Company name and address where training is provided	Regular	Overtime	*1	*2	*3	*4	*5	

*1 = Daily *2 = Weekly *3 = Every two weeks *4 = Twice monthly *5 = Monthly

5. Do you or anyone else in your household receive money from the following sources? (Check Yes or No)

	Yes	No
Social Security		
Supplemental Social Income (SSI)		
Veteran's benefits and or pensions		
Railroad retirement		
Other retirement benefits or pensions		
Welfare checks (AFDC)		
Cash, gifts, or contributions from parents, relatives, friends, others		
Unemployed checks		
Worker's compensation		
Payments from private insurance		
Union benefits (including strike benefits)		
Military allotments		
Money from rent of houses or apartments		
Money from roomers or boarders in your house		

	Yes	No
Child support and/or alimony		
Dividends from stocks and bonds		
Interest from savings accounts or certificates of deposit		
Money from oil, gas or mineral leases or royalties		
Money from other private or public welfare agencies		
Money from farm (including pasture rental, ASC payments, livestock, or other related money)		
Other money (included loans made to you and any lump-sum (one time) payments received)		
Educational loans, grants or scholarships		
List other income		

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If you answered 'Yes' to any of the last section, complete the following

Name of person receiving money	Who provides the money	If Social Security, enter claim #	Amount received	How often received

6. During the last 4 months, have you or the household members, for whom you want assistance, received medical services which have not yet been paid for? ☐ Yes ☐ No

7. Do you expect to have any medical expenses during the next 6 months? ☐ Yes ☐ No

8. Are you or anyone in your family now covered by any private medical insurance? ☐ Yes ☐ No If, yes, complete the following:

Insurance company name	Policy #	Group #	Name of policy holder	
Address of insurance company	City		State	Zip
Employment related? ☐ Yes ☐ No	If yes employer name			
Beginning coverage date	Ending coverage date	Name of persons covered by the policy		

9. Have you or anyone who lives with you been covered in the last 6 months by any health insurance policy under which you are no longer covered? ☐ Yes ☐ No If yes, complete the following:

Insurance company name	Policy #	Group #	Name of policy holder	
Address of insurance company	City		State	Zip
Employment related? ☐ Yes ☐ No	If yes, employer name			
Beginning coverage date	Ending coverage date	Name of persons covered by the policy		

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10. List your monthly expenses below:

	Amount	How often billed	Date last payment made
Rent or house payment			
Taxes, special assessments			
Home insurance payments			
Telephone			
Utilities (gas, electric, etc.)			
Food			
Charge accounts			
Medical expenses			
Loans			
Other (specify)			

11. Do you or anyone else in your household pay for someone to care for a child or a disabled or elderly adult so that you can work or get training? ☐ **Yes** ☐ **No** If yes, complete the following:

Who provides the care?	How often?	How much does it cost?	
Address of person who provided the care	City	State	Zip

12. Do you or anyone who lives with our have any of the following? If yes, give value:

	Yes	No	Value
1. Savings account, or Credit Union account			
2. Checking account			
3. Cash			
4. Stocks, bonds etc.			
5. Oil, mineral rights			

	Yes	No	Value
7. Burial insurance (face value)			
7. Burial insurance (face value)			
8. Property (real estate)			
9. Livestock			
10. Cars, Trucks, Motorcycles, Boats and other vehicles			

List year, make and model for each vehicle

Year	Make	Model

13. Do you or anyone who lives with you own or are you buying anything not listed above? ☐ Yes ☐ No
If yes, list them below (do not list household items such as furniture or personal items such as jewelry or clothing)

14. Did you or a member of your household sell, trade or give away anything valuable during the last year?
☐ **Yes** ☐ **No** If yes, list them below (do not list household items such as furniture or personal items such as jewelry or clothing)

15. If someone else is helping you fill in this form, give his/her name and address:

Name		Telephone #	
Address	City	State	Zip

16. Give the name and address of a relative or friend to contact in case of an emergency:

Name		Telephone #	
Address	City	State	Zip

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I agree that all questions and statements I have made are true and correct to the best of my knowledge.

I agree to give eligibility staff at the hospital any information to prove statements about my eligibility for financial assistance. I will cooperate fully with the hospital personnel to get information from any source to prove the statements I made.

I have been told and understand that my failure to meet the obligations set forth may be considered willful withholding of information and can result in the recovery of any loss by repayment, or by filing criminal or civil charges against me.

I certify that I am applying for services under the Methodist Hospital for Surgery Financial Assistance Policy. I am, or the person responsible for me is, financially unable to pay for all the cost of the necessary services.

I agree to report any changes in the following, within 14 days, income, resources, numbers of people who live with me, address, or other circumstances that may affect my eligibility for financial assistance.

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, handicap, or political belief.

BEFORE YOU SIGN BE SURE EACH ANSWER IS COMPLETE AND CORRECT

Signature - Applicant	Date
Signature - Witness	Date
Signature - Witness	Date

For office use only

Form received by		Date
Form reviewed by		Date
Financial Assistance ☐ Approved ☐ Not approved		Date
If **approved**, level approved ☐ Full ☐ Partial	Amount approved	Date
If **not approved**, reason for denial		
		Date