FINANCIAL INFORMATION FORM / FINANCIAL ASSITANCE APPLICATION

For assistance completing this form or if you have questions, please call 281-243-1073

Patient Name:

Patient Street Address: City, State, Zip Code:

Account Number(s): Date(s) of Service:

INSTRUCTIONS: All questions must be answered. If a question does not pertain, write N/A on the line.

Attach a photocopy of <u>one</u> proof of identity with a picture (example: state-issued driver license or Passport with picture, etc.) *

Attach a photocopy of the most recent Income Tax return *<u>or</u>*

Attach a photocopy of <u>one</u> of the following proofs of income:

** If photo ID is not available, other documents showing identity may be used. Contact phone number above for assistance.*

- ☐ Last 2 paycheck stubs
- ☐ Unemployment benefit confirmation slip
- ☐ Social Security check or award letter
- ☐ Letter from employer stating employee name, occupation, hourly wage, number of hours worked

****** This is not considered a complete application without the supporting documentation. ******

STATUS: ☐ Permanent Texas Resident ☐ Legal Resident ☐ Immigrant Visa ☐ Non-Immigrant Visa

MARITAL STATUS (check one): ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

CHILDREN UNDER 18 YEARS OLD AND OTHER DEPENDENTS WITHIN THE HOUSEHOLD (Continue on another page, if needed)

Full Name	Date of Birth	Relationship of Dependents (check one)				
		Child	Step-Child	Guardian	Adult/Senior	Not Related

EMPLOYMENT SUMMARY

Patient	Spouse
Employer	Employer
Occupation	Occupation
Employment Status (check one) ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Housewife ☐ Unable to return to work	Employment Status (check one) ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Housewife ☐ Unable to return to work

HOUSEHOLD INCOME PER MONTH		HOUSEHOLD EXPENSES PER MONTH	
Patient	$ /mo.	Housing: ☐ Own/Loan ☐ Rent	
Spouse	$ /mo.	House Payment	$ /mo.
Alimony	$ /mo.	Utilities (electric, water)	$ /mo.
Unemployment	$ /mo.	Car # 1	$ /mo.
Child Support	$ /mo.	Car # 2	$ /mo.
Survivors Benefit	$ /mo.	Gasoline	$ /mo.
Workers Comp	$ /mo.	Insurance	$ /mo.
Trust Fund	$ /mo.	TV/ Cable / Phone	$ /mo.
Other	$ /mo.	Food	$ /mo.
TOTAL INCOME	**$** /mo.	**TOTAL EXPENSES**	**$** /mo.

BANK ACCOUNTS/OTHER ASSETS (must answer all 3 questions):

Checking Account? (circle one)	Yes	No	Current Balance	$
Savings Account? (circle one)	Yes	No	Current Balance	$
Additional Property? (circle one)	Yes	No	Current Value	$
			If Yes, please describe:	

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Patient Name:

* I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.

* The information I provided reflects HOUSEHOLD income and expenses.

* This information as well as a credit report and other publicly available information may be used by Memorial Hermann to establish a payment plan and/or to initiate an application for financial assistance and/or to determine eligibility for various programs, coverage or assistance.

* I give my consent to Memorial Hermann to obtain information from any source to verify the statements I have made.

* You will receive written communication from Memorial Hermann if the information provided is incomplete or insufficient to determine your eligibility for financial assistance or if you do not meet the eligibility qualifications. You will also be notified in writing if you are eligible for financial assistance.

* Patients who apply for financial assistance may be eligible for funds from local, state, or federal programs. Patients are expected to apply for such programs before a determination of eligibility for financial assistance. Memorial Hermann will provide assistance to individuals in applying for such programs. If a patient refuses to apply for, or follow through with an application for Medicaid or other coverage, the patients Financial Assistance Application will be denied.

* I affirm to the fact that I have applied for all possible insurance coverage, including Medicaid, Crime Victims, Health Exchange Insurance and any other local, state or federal coverage.

* I understand that if I do not qualify for financial assistance, I will be responsible for the cost of the care .

Patient/Guarantor Signature _____ Date _____

After completing this application, mail it and ALL supporting documents to:

Patient Business Services
16906 Southwest Freeway
Sugar Land, Texas 77479
Attention: Patient Financial Assistance

Office Use Only
Financial Assistance Approved by Facility CEO / CFO

Approved by: _____ _____
Name / Signature Title Date

MEMORIAL HERMANN

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