Methodist
HEALTH SYSTEM

# Financial Assistance Application

**Guarantor ID**

Patient's Name (Last, First, MI) | Social Security Number | Date of Birth

Patient's Address | City | State | Zip | County

Marital Status check one:
____ Married ____ Single ____ Widowed ____ Separated/Divorced

Date of Birth (Month/Day/Year) | Telephone Number

Patient Employed Yes No

Patient's Employer:_____

Telephone Number:_____

Spouse Employed Yes No

Spouse's Employer:_____

Telephone Number:_____

A. Income Please provide the income for each of the following persons in your household.

**Patient** Full Time Part Time

Hours/Week =_____

$ _____ Hr Wk Bi-Wk Month Year

$_____ **Additional Income**

**Spouse** Full Time Part Time

Hours/Week =_____

$ _____ Hr Wk Bi-Wk Month Year

$ _____ **Additional Income**

**Total Household Income $ _____**

**B.** ***Income Verification:*** Please provide 2 forms of Income Verification ***(send only copies, no original documentation)*** for all sources of household income **for the last 90 days** (acceptable documentation listed below).

**Tax Statement (Recommended)** **Bank Statement (Recommended)** **Paycheck Remittance**

If you are unable to give the recommended documentation please state why.

**C.** ***Family Members:*** **Please provide the total number of people in the patient's household.**

(This number should only include the patient, patient's spouse, and the patient's dependents)

**D.** ***Assets and Other Resources: Please circle your answer***

| | | | |
|---|---|---|---|
| Do you have any assets or other resources available to you? (Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.) | Yes | No | If Yes, current amount available: $_____ |
| Do you have medical insurance? | Yes | No | If Yes, please list provider name: _____ |
| Do you have a Health Savings Account or Flexible Spending Account? | Yes | No | If Yes, current amount available: $_____ |

I understand Methodist Health System (MHS) may verify the financial information contained in this Financial Assistance Application ("FAP") in connection with MHS's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize MHS to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance. I further understand physicians and providers are not employees of MHS. I understand that I may receive separate bills from those providers and this financial assistance application does not apply to those balances due.

**Signature of Patient or Responsible Party** | **Printed Name** | **Date**

40795E (11-20)

**Mail Completed Application to:**

**Methodist Health System**
**CC 90840**
**PO BOX 655999**
**Dallas, TX 75265-9969**