



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 _____ Spouse Employed Yes No _____

Patient's Employer: _____ Spouse's Employer: _____

Telephone Number: _____ Telephone Number: _____

A. Income Please provide the income for each of the following persons in your household.	
Patient	Spouse
Full Time Part Time	Full Time Part Time
Hours/Week = _____	Hours/Week = _____
\$ _____ Hr Wk Bi-Wk Month Year	\$ _____ Hr Wk Bi-Wk Month Year
\$ _____ Additional Income	\$ _____ 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 _____

Mail Completed Application to: **Methodist Health System
 CC 90840
 PO BOX 655999
 Dallas, TX 75265-9969**