USMD Hospital at Arlington
801 W. Interstate 20
Arlington, TX 76017
817-472-3400

Date:_____ Guarantor Name: _____

Patient Name: _____ Date of Service: _____

Hospital Account #_____ Medical Record # _____

Dear Patient:

Attached you will find the USMD Hospital at Arlington 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 USMD Hospital at Arlington 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: Last _____ First _____ MI _____

Social Security # _____ DOB: _____ Hospital Account # _____

Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

Do you have minor children (under 18)?	_____ Yes	_____ No
Do they live with you?	_____ Yes	_____ No
Are they your birth/legally adopted children?	_____ Yes	_____ No
Patient Employed?	_____ Yes	_____ No
Spouse Employed?	_____ Yes	_____ No
Do you have medical insurance?	_____ Yes	_____ No
Are you on disability? How long? _____	_____ Yes	_____ No
Are you a veteran?	_____ Yes	_____ No

FAMILY MEMBERS – (Living in the home)

Spouse: _____
Child: _____ Age: _____
Child: _____ Age: _____
Child: _____ Age: _____
Child: _____ Age: _____

INCOME (Monthly Amount):

	Gross	Net
Patient	$_____	$_____
Spouse	$_____	$_____
Dependants	$_____	$_____
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	$_____	$_____
TOTAL	$_____	$_____

Expenses	Monthly Amount
Mortgage/Rent	$_____
Utilities	$_____
Car Payments	$_____
Food / Groceries	$_____
Credit Cards	$_____
Other (please specify) _____	$_____
TOTAL	$_____

ASSETS

Checking Account $_____
Savings Account $_____
CD's, IRA's $_____
Other Investments (Stocks, bonds, etc.) $_____
Properties/Land other than primary residence $_____

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APPLICATION FOR FINANCIAL ASSISTANCE – Page 2

Name of Employer _____ Spouse's Employer: _____

Telephone # _____ Telephone # _____

Employer Address _____ Employer Address _____

Occupation _____ Occupation _____

Are you currently applying for Medicaid Benefits? _____ Yes _____ No

Have you applied for assistance thru your county hospital/indigent program? _____ Yes _____ No

Is your physician donating his/her services? _____ Yes _____ No

Are there any potentially liable third-parties responsible for your accident/injury/ illness? _____ Yes _____ No

Is anyone assisting you with payment of your hospital bills? _____ Yes _____ No

Who is assisting you? _____

How much assistance are you receiving? _____

List any other information you feel would be helpful to us in determining your eligibility for assistance in paying your hospital bill.

_____

_____

_____

Expected earnings and/or funds you will receive during your time off due to your illness. (Sick leave, paid time off, short/long term disability income). $_____

Expected length of time you will be unable to work and/or earn wages: _____

I understand that USMD Hospital may verify the financial information contained in this application in connection with the hospital's evaluation of this application, and hereby authorize the hospital to contact my employer to certify the information provided and to request reports from credit reporting agencies. I am aware that this information will be used to determine my eligibility for financial assistance and that the falsification of information in this application may result in denial of Financial Assistance care assistance. I also understand that any Financial Assistance approval may be completely or partially reversed in the event of a recovery from a third-party or other source.

I further understand that any Financial Assistance care I receive shall not be construed as a waiver by hospital of its hospital lien for reimbursement of any amount I owe and that any reimbursement I receive relating to this hospitalization must be sent to USMD Hospital at Arlington.

_____ _____

Signature of Person Making Request, If Patient Date

_____ _____

Signature of Person Making Request, If Not Patient Relationship

_____ _____

Patient's Address City State ZIP County Home Telephone Number