



801 W. Interstate 20, Arlington, TX 76017 | Phone 817.472.3505 | Fax 817.472.3452

Date: _____ Guarantor Name: _____

Patient Name: _____ Date(s) of Service: _____

Account # _____ Medical Record # _____

Dear Patient and/or Guarantor-

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, physician, or urgent care bill(s). This is for your USMD Hospital at Arlington outstanding balances 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 Resources 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.

Proof of income is required to process the application. Please see acceptable documents below. Failure to provide the requested documentation can result in a denial for financial assistance consideration.

It is 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 our team. Your cooperation is required to complete your application.

PROOF OF INCOME DOCUMENTS NEEDED WILL DEPEND ON YOUR FINANCIAL CIRCUMSTANCES.

ANY OR ALL OF THE FOLLOWING DOCUMENTS MAY BE REQUIRED TO DETERMINE THE OUTCOME OF YOUR FINANCIAL ASSISTANCE CASE.

1. Pay stubs from all employment – 3 current pay stubs for each job held.
2. Social Security or pension statements
3. Self-employed must provide a personal tax return from the most recently filed calendar year and 3 months of detailed personal bank statements.
 - a. Tax return = Personal 1040 plus schedule 1 and any other schedules referenced on schedule 1
4. W-2 or 1099 statements for all employment during the relevant time-period.
5. Unemployment benefits - Forms approving or denying unemployment compensation.
6. Proof of child support income – Attorney General summary preferred.
7. Proof of available resources – detailed personal bank statements
8. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance.
9. Written statements from employers or welfare agencies.
10. Signed letter of support from the party providing food and shelter needs.
11. Proof of Worker’s Compensation income
12. Disability income short term or long-term disability income statement
13. Forms approving or denying eligibility for SNAP benefits.

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 USMD medical 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 USMD medical bills.

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 evaluation of this application, and hereby authorize USMD 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. 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.

[Third Party Liability only] 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