UT Southwestern Medical Center

RE: Financial Assistance Application

Dear: Patient

In accordance with its mission to enhance the health of the community and the state of Texas, UT Southwestern Medical Center (UTSW) provides care for the most vulnerable patients in the community, including patients with financial hardships. Attached you will find the UTSW Application for Financial Assistance. Completion of this application will enable us to review your account for consideration of financial assistance. To determine if you qualify for financial assistance, we require the following information: (Please refer to the Required Documentation List for acceptable forms of documentation)

- Verification of Income
- Verification of Household size
- Verification of Residency
- Verification of Identity

UT Southwestern may need to share a limited amount of your health information to obtain or provide payment for the health care services provided to you. Please refer to our Notice of Privacy Practices or visit our HIPAA Privacy Office online for more information at www.utsouthwestern.edu/about-us/administrative-offices/compliance/hipaa for more information.

Please complete each item on the application. If you need additional space for any explanations, please utilize the back of the application. If you have difficulty completing this application or there is an area that is unclear, please call the Financial Assistance Department, Monday through Friday, from 8:00 a.m. to 5:00 p.m. at 469-291-2000 or Toll Free 866-648-2455.

It is important that you complete this application upon receipt and return it with all the required documentation within 15 days. Your completed Financial Assistance Application and supporting documentation can be sent to FinancialAssistance@UTSouthwestern.edu or mailed to:

UT Southwestern Medical Center (Mail Code 9233)
Attn: Financial Assistance
P.O. Box 36423
Dallas, Texas 75235-9662

Your cooperation is appreciated. Submission of completed application and required documentation does not guarantee approval for financial assistance, and that you remain responsible for your account balance.

Sincerely,

Financial Assistance Office
UT Southwestern Medical Center

UT Southwestern Medical Center

Required Documentation List

Please submit items from each category listed below that is dated within the last 60 days. Requested documentation applies to applicant and everyone who lives in applicant's household. Additional documentation may be required on request.

Income

(1 item required; additional documentation may be required on request)

- Last 4 payroll check stubs (required for employed)
- Last 2 month checking and savings account statement
- Employment verification form, written or faxed from employer on company letterhead
- Workers Compensation
- Unemployment Award Letter / Denial
- Social Security Award Letter
- Retirement Income, Pensions, CD's, IRA, Federal Income Tax form 1099
- Income Tax Return, previous year from application date. (required for self-employed with all schedule's)
- Personal work or day labor records (lawn mowing, painting, babysitting, house cleaning)
- Court order for child support / alimony

Residency

(1 item required; additional documentation may be required on request)

- Utility bills or utility company record
- Rent receipt or statement from non-relative landlord
- Mortgage receipt or statement from Mortgage Company
- Valid Texas driver's license or Department of Public Safety ID card
- Voter's registration card
- Official records confirming ownership of property
- Item of business mail with household name and address

Note: Mail addressed to a P.O. Box cannot be used for proof of residency.

Household

(1 item required; additional documentation may be required on request)

- Income Tax return, previous year from application date
- Married requires income verification of spouse
- Separated requires notarized letter of separation with documentation of separate address for 2 years
- Local, State or Federal government records
- Court-ordered guardianship / conservatorship
- Student Transcript's / School records

Identity (ID)

(1 item required)

- Driver's license issued by State of Territory
- Identification card issued by the Federal, State, or Local Government
- Employment ID
- School identification card
- U. S. military card or draft record
- Military dependent's identification card
- U.S. Coast Guard Merchant Mariner card
- Passport
- Matricula Consular, issued by Government of Mexico
- U. S Citizenship & immigration Service Records

Other / Asset's

(Any information on the following ; additional documentation may be required on request)

- Checking account / Savings Accounts
- Insurance/Lawsuit Settlements
- Real Estate/Rental Property
- Stocks/Bonds/Certificates of Deposit
- Retirement (including IRAs)
- Alien Sponsor's Resources
- Determination letters from any organization providing support or assistance such as Parkland Health and Hospital System, John Peter Smith Hospital, Other County Indigent Health Programs or Department of Health and Human Services (SNAP, MEDICAID)

UT Southwestern Medical Center

APPLICATION FOR FINANCIAL ASSISTANCE

The service were provided by (check all that applies):		
☐UTSW Hospital and Clinics	☐UTSW Cancer Center	☐UTSW Infusion Center

PLEASE PRINT CLEARLY

Patient Name (Last, First, Middle)	Medical Record Number	Date of Birth	Phone Number	Alternate Phone Number

Mailing Address (Street, P.O. Box, or RFD)	City	State	Zip

Home Address (if different from Mailing Address)

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated (Requires documentation of separate addresses for 2 year)

ANSWER EVERY QUESTION. Write "NA" if the question does not apply. This application should be completed by or for the patient.

1. **Fill in all blanks for everyone who lives with you (patient), whether you consider them household members or not.**

NAME Last First Middle	AGE	RELATIONSHIP	MARRIED Y N	STUDENT Y N	EMPLOYED Y N	DISABLED Y N	SOCIAL SECURITY #
		PATIENT					

2. **Are you (patient) or anyone in your family now covered by any private health insurance?**..... ☐Yes ☐No
(If "Yes", complete the following items about private health insurance)

Insurance Company Name		Name of Policy/ Subscriber Holder
Relationship to Patient	Employment Related? ☐Yes ☐No	If "Yes", Employer Name

3. **Have you (patient) or anyone who lives with you been covered during the last 3 months by any health insurance policy under which you are no longer covered?**..... ☐Yes ☐No
(If "Yes", complete the following)

Insurance Company Name		Name of Policy/ Subscriber Holder
Relationship to Patient	Employment Related? ☐Yes ☐No	If "Yes", Employer Name
Ending Coverage Date	Entitled to COBRA? ☐Yes ☐No	If "Yes" COBRA Administrator

4. **Does anyone who lives with you (patient) receive benefits from?** (check "Yes" or "No" for each type of program)

Aid to Families with Dependent Children	SSI	Food Stamps	Social Security	Medicaid	WIC
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

5. **Has your (patient) illness restricted you from working?** ..... ☐Yes ☐No
(If 'Yes", expected length of inability to work)..... | Length of time |

6. **Do you (patient) or anyone who lives with you have a job (including day work, babysitting, etc.) or are any of you in training for a job?** ☐Yes ☐No (If "Yes", fill out the blanks for each person who is in training or is employed (including self-employment)

Name of person working	Name of Employer / Occupation	Number Hours Per Week	How Often Paid? *1	*2	*3	*4	*5	Hourly Rate/ Salary

*1 = Daily *2 = Weekly *3 = Every Two Weeks *4 = Twice Monthly *5 = Monthly

7. **Do you (patient) or anyone else in your household receive money from the following sources?**
(Check "Yes" or "No", if "Yes List Gross Amount per Month):

	Y	N	Amount
Social Security			$
Supplemental Security Income (SSI)			$
Veteran's Benefits and or Pensions			$
Railroad Retirement			$
Other Retirement Benefits or Pensions			$
Money from Roomers or Boarders in Your House			$
Cash, Gifts, or Contributions from Parents, Relatives, Friends, Others			$
Unemployment Checks			$
Worker's Compensation			$
Payments from Private Insurance			$
Union Benefits (including strike benefits)			$
Military Allotments			$
Money from Rent of Houses/Apartments			$
Welfare Checks (AFDC)			$

	Y	N	Amount
Child Support and/or Alimony			$
Dividends from Stocks and Bonds			$
Interest from Savings Accounts or Certificates of Deposit			$
Money from Oil, Gas, or Mineral Leases or Royalties			$
Money from Other Private or Public Assistance Agencies			$
Money from Farm (including pasture rental, ASC payments, Livestock, or other related money)			$
Other Money (include loans made to you and any lump-sum (one time) payments received)			$
Educational Loans, Grants, or Scholarships			$
Short Term Disability			$
Long Term Disability			$
Food Stamps			$
List Other Income:			
			$
			$

8. **List your (patient) monthly expenses below:**

	Amount
Rent or House Payment	$
Utilities (gas, electric, etc.)	$
Telephone/ Cable/Internet	$
Food	$
Credit Card Accounts	$
Car Payment	$

	Amount
Home/Car Insurance Payments	$
Gasoline	$
Taxes, Special Assessments	$
Loans	$
Child Care	$
	$

9. **Do you (patient) or anyone who lives with you have any of the following check ("Yes" or "No", if "Yes", give value):**

	Y	N	Value
A. Savings Account or Credit Union Account			$
B. Checking Account			$
C. Cash			$
D. Stocks, Bonds, etc. Year Make Model			$
E. Oil, Mineral Rights			$
F. Life Insurance (face value)			$
G. Burial Insurance (face value)			$
H. Property (real estate)			$
I. Livestock			$

	Y	N	Value
J. Cars, Trucks, Motorcycles, Boats, etc...			$

List year, make and model for each vehicle:

Year	Make	Model

10. **Are you (patient) currently applying for Medicaid benefits?** ..... ☐Yes ☐No

11. **Are there any potentially liable third parties responsible of any accident/injury/illness?** (check "Yes" or "No" for each)

Auto Insurance	Commercial Insurance	Residential Insurance	Worker Compensation	Other	Victim of Crime
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

(If "Yes", complete the following items about personal/auto/liability insurance)

Insurance Company Name		Responsible Party	
Claim Number	Date of Injury	Adjuster/Case Worker	Phone

12. **Have you (patient) applied for assistance through your county Indigent program?** ☐Yes ☐No

County

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

_____

_____

14. **Please refer to the "Required Documentation List" for acceptable forms of documentation.**

I understand that UT Southwestern Medical Center may verify the financial information contained in this application in connection with the evaluation of this application, and I hereby authorize UT Southwestern Medical Center 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 complete or partially reversed in the event of eligibility and/or recovery of payment from a third party or other source. I affirm that all statements made in this application are true and correct to the best of my knowledge.

I further understand that any financial assistance I receive shall not be construed as a waiver by UT Southwestern Medical Center of its rights to enforce a hospital and/or physician lien for reimbursement of its full-billed charges and that any reimbursement I receive relating to services provided by UT Southwestern Medical Center must be sent to UT Southwestern Medical Center.

_____ _____/_____/_____

Signature of Patient/Responsible Party (Relationship to Patient) DATE