Financial Assistance Application

Your cooperation in completing this application and providing the requested documentation will help to determine if you qualify for financial assistance for your hospital charges. The information you provide will be checked for accuracy and with the exception of verification; your information will be treated confidentially. Filling out this form does not guarantee financial assistance. If it is determined that that you do not qualify for financial assistance, you will remain responsible for payment of your hospital bill.

_____ _____ _____
Patient's Name Date of Birth Social Security No.

_____
Address Street/City/ State/ Zip Code

Mailing Address, if applicable:_____

(_____)_____ (_____)_____ _____
Home Phone Cell Phone Patient Account Number

If no Social Security #., Citizenship_____ Resident Alien Number _____

Do you have health insurance now? Yes ☐NO☐ If No, have you applied for health insurance? Yes ☐NO ☐_____

If you have health insurance, name of insurance and policy number: _____

_____

_ Have you applied for assistance with your county hospital/indigent program? Yes ☐NO☐

If Bexar County Resident, have you applied for CareLink? Yes ☐NO☐

Patient Employed? Yes ☐NO☐ Spouse Employed? Yes ☐NO☐ N/A(no spouse)☐

_____

Patient Employer (Name, Address and Telephone Number) If Patient is a Minor, Employer of Patient's Father

_____

Spouse Employer (Name, Address and Telephone Number) If Patient is a Minor, Employer of Patient's Mother

_____

Spouse Name Social Security Number Birth Date (Month/Day/Year)

Name all persons living in the patient's household:

Spouse: _____

Name: _____ Relationship: _____Age: _____

Name: _____ Relationship: _____Age: _____

Name: _____ Relationship: _____Age: _____

Name: _____ Relationship: _____Age: _____

Name: _____ Relationship: _____Age: _____

Total Number of persons in the patient's household: _____

_____

Patient's Father (If patient is a minor) Social Security Number Birth Date (Month/Day/Year

_____

Patient's Mother (If patient is a minor) Social Security Number Birth Date (Month/Day/Year)

If the applicant is an adult, does anyone else declare applicant as a dependent in their tax documents? Yes ☐ NO☐

If Yes, provide name, address and phone number of person who declares applicant as a dependent: _____

Name

_____

Address Street/City/County/State/ Zip Code Phone Number

Income Verification: Provide the following types of documentation to verify household income:

- ○ Paycheck Stub Remittance or Employer Verification to include Wages and Tax Statement
- ○ If no check stubs, submit copies of bank statements reflecting monthly deposits
- ○ If self-employed, must submit most current personal income tax return and current profit and loss statement
- ○ Proof of Participation in Governmental Assistance programs such as Medicaid or AFDC
- ○ Social Security or Unemployment Compensation Determination Letters
- ○ Other (Describe) _____

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available: _____

Wages: Provide the wages for each of the following persons in your household.

	Circle One		Circle One
Patient $_____	Hour/ Week/ Month/ Year	**Patient's Father** (if patient is a minor) $_____	Hour/ Week/ Month/ Year
Spouse $_____	Hour/ Week/ Month/ Year	**Patient's Mother** (if patient is a minor) $_____	Hour/Week/ Month/ Year

Other Resources: Provide the total amount of other resources available to you:

Savings accounts $_____ Checking accounts $_____ Cash on Hand $_____

Other investments $ _____ CD's, IRA's $_____ Rental Income $_____
(Stocks/bonds, etc.)

Estimated Value of Home, if owned $_____ Estimated Value of any other owned property $_____

INCOME (Monthly Amount):

	Gross	Net	Expenses	Monthly Amount
Patient	$_____	$_____	Mortgage/Rent	$_____
Spouse	$_____	$_____	Electric	$_____
Dependents	$_____	$_____	Phone/Cable	$_____
Public Assistance	$_____	$_____	Water Bill	$_____
Food Stamps	$_____	$_____	Food/Groceries	$_____
Social Security	$_____	$_____	Car Payment(s)	$_____
Unemployment	$_____	$_____	Credit Cards	$_____
Child Support	$_____	$_____	Medical Insurance	$_____
Worker's Comp	$_____	$_____	Auto Insurance	$_____
Pension(s)	$_____	$_____	Child Support	$_____
Rental Income	$_____	$_____	Medications	$_____
Rental Income	$_____	$_____	Medical Bills	$_____
CD's/Dividends	$_____	$_____	Other (Specify)	$_____
Other (Specify)	$_____	$_____		
TOTAL	**$_____**	**$_____**	**TOTAL**	**$_____**

Patient's Annual Gross Income*: $_____

* For adult patients, "Annual Gross Income" means the sum of the annual gross income (i.e., income before taxes) of the patient and the patient's spouse. For minor patients, "Annual Gross Income" means the annual gross income of (i) the patient and (ii) the patient's mother, the patient's father, and any other person(s) responsible for the patient's care.

If no income, how do you support yourself/family?_____

_____

Was your hospitalization the result of a motor vehicle accident? Yes ☐ NO☐ **If Yes, must provide accident report**
Did you receive Auto Insurance Money? Yes ☐ NO☐ If Yes, amount $_____
Are you awaiting payment from auto or home owner insurance? Yes ☐ NO☐ If Yes, amount $_____
Name and Contact Information of Insurance Adjuster: _____

I understand University Health System can verify the financial information contained in this Application, and by my signature I hereby authorize UHS to contact my employer and my spouse and anyone who names me as a dependent on their taxes, to verify the information provided in this Application. I also authorize University Health System to request reports from credit reporting agencies. I certify that this information is true to the best of my knowledge and I am aware that falsification of information on this Application may result in denial of financial assistance. In consideration for receiving health care services as a result of an accident or injury, I agree to reimburse University Health System from proceeds of any litigation or settlement resulting from such act. I also understand that any financial assistance is based on my inability to pay and that if any new source of income or third party payer becomes available, University Health System can reverse its grant of financial assistance in whole or in part. I understand that if I do not qualify for financial assistance, I remain responsible for my hospital charges.

_____ Date_____
Signature of Patient or Responsible Party