Financial Assistance Application

Acct #

Baylor Scott & White HEALTHTEXAS PROVIDER NETWORK

Patient Information

Patient Last Name	First Name	Middle Name	
Date of Birth	Social Security #	Telephone Number	
Address	City	State	Zip
Employer Name (If unemployed, list previous employer information.)		Employer Telephone Number	
Employer Address (Street or Box)	City	State	Zip

Spouse or Legal Guardian Information

Spouse or Guardian Last Name	First Name	Middle Name	
Date of Birth	Social Security #	Telephone Number	
Address (Only if different than above)	City	State	Zip
Employer Name (If unemployed, list previous employer information.)		Employer Telephone Number	
Employer Address (Street or Box)	City	State	Zip

Section-A (Income)

Please provide the income for each of the following persons in your household.

(This section is only used when the patient is a minor)

Patient Income: $	Frequency: ☐ Hour ☐ Week ☐ Month ☐ Year	Father Income: $	Frequency: ☐ Hour ☐ Week ☐ Month ☐ Year
Spouse Income: $	Frequency: ☐ Hour ☐ Week ☐ Month ☐ Year	Mother Income: $	Frequency: ☐ Hour ☐ Week ☐ Month ☐ Year
Total Income: $		Total Income: $	

Section-B (Family Members)

Please provide the number of people in the patient's household: #

Section-C (Income Verification)

Please provide **ONE** of the following document types to verify income. These document types are listed in order of preference.

1. Paycheck Remittance
2. IRS Form W-2
3. Tax Return
4. Employer Verification
5. Social Security, Workers Compensation or Unemployment Compensation Determination Letters
6. Proof of Participation in Government Assistance (food stamps, CDIC, Medicaid or AFDC)
7. Bank Statements
8. Other_____

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

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Section-D (Assets and Other Resources)

Do you have any assets or other resources available to you? (Savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)	☐ Yes ☐ No	If Yes, current amount available:	$
Do you have a Health Savings Account?	☐ Yes ☐ No	If Yes, current amount available:	$
Do you have a Medical Flexible Spending Account?	☐ Yes ☐ No	If Yes, current amount available:	$
Do you have medical insurance?	☐ Yes ☐ No	If Yes, please list insurance name:	

I understand **HealthTexas Provider Network** ("HTPN") may verify the financial information contained in this Financial Assistance Application ("Application") in connection with HTPN'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 HTPN 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.

Signature of **Patient** or **Responsible Party** | Printed Name | Date

Signature of **HTPN Employee**
(Only if assisted in completion of application) | Printed Name | Date

HTPN Use Only

Income Verification

Name of Person Contacted (1)	Date	Information Obtained
Name of Person Contacted (2)	Date	Information Obtained

HTPN Employee Signature | Date

Notes regarding number in household:

If Patient / Legal Guardian are unable to sign the application, explain why: