



Arlington Memorial Hospital
Harris Methodist Hospitals
Presbyterian Hospitals

500 E Border Street #130
Arlington Texas 76010
682-236-3000 / 800-890-6034
THRFinancialassistance@texashealth.org

Date: _____ Guarantor Name: _____

Patient Name: _____ Date of Service: _____

Hospital Account # _____ Medical Record # _____

- | | | |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Texas Health Allen | <input type="checkbox"/> Texas Health Flower Mound | <input type="checkbox"/> Texas Health Rockwall |
| <input type="checkbox"/> Texas Health Alliance | <input type="checkbox"/> Texas Health Frisco | <input type="checkbox"/> Texas Health Southlake |
| <input type="checkbox"/> Texas Health Arlington Memorial | <input type="checkbox"/> Texas Health Fort Worth | <input type="checkbox"/> Texas Health Southwest Fort Worth |
| <input type="checkbox"/> Texas Health Azle | <input type="checkbox"/> Texas Health Heart & Vascular Hospital Arlington | <input type="checkbox"/> Texas Health Specialty Hospital |
| <input type="checkbox"/> Texas Health Burleson | <input type="checkbox"/> Texas Health HEB | <input type="checkbox"/> Texas Health Springwood |
| <input type="checkbox"/> Texas Health Center for Diagnostic Surgery Plano | <input type="checkbox"/> Texas Health Kaufman | <input type="checkbox"/> Texas Health Stephenville |
| <input type="checkbox"/> Texas Health Cleburne | <input type="checkbox"/> Texas Health Plano | <input type="checkbox"/> Texas Health Urgent Care |
| <input type="checkbox"/> Texas Health Dallas | <input type="checkbox"/> Texas Health Prosper | |
| <input type="checkbox"/> Texas Health Denton | <input type="checkbox"/> Texas Health Recovery & Wellness Center | |

Dear Patient:

Attached you will find the Texas Health Resources Financial Assistance Application. Completion of this application will enable us to present your account for consideration of financial assistance for your hospital or urgent care bill(s). This is for your hospital or urgent care 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 Texas Health 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.

Please provide copies of your last three pay stubs and/or proof of any other form of income for the household. If you cannot obtain check stubs, please provide copies of the last three months of personal checking and savings account statements. 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 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 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 Texas Health Resources 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 Texas Health Resources.

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