Guarantor Name: Account Number:
Date of Birth: Telephone:
Address:

Dear Guarantor:

Attached you will find the Texas Health Physicians Group Financial Assistance Program Application. Completion of this application will enable us to present your account for consideration of financial assistance for your physician bill(s). This is for your Texas Health Physicians Group professional charges incurred only with your physician and not related to any hospital charges, drug expenses or other ancillary services.

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 Physicians Group 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 current month and two prior months' pay stubs and / or proof of any other form of income for the household. If you do not receive check stubs, please provide copies of your bank statements showing your monthly deposits. 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 extremely important that you complete this application upon receipt. Please return to the address below:

Texas Health Physicians Group
PO Box 733509
Dallas, TX 75373-3509

This application may be obtained on your clinic's website, the clinic or from Patient Advocacy. If you have difficulty completing this application or there is an area that is unclear, please call 1-855-602-5273. Your cooperation is appreciated.

Texas Health Physicians Group

APPLICATION FOR FINANCIAL ASSISTANCE

Guarantor Name (Last, First, MI):_____

Social Security Number:_____ Date of Birth:_____

Married:_____ Single:_____ Divorced:_____ Widowed:_____ Separated:_____

	Yes	No
Do you have minor children (under 18)?		
Do they live with you?		
Are they your birth / legally adopted children?		
Guarantor employed?		
Spouse employed?		
Do you have medical insurance?		
Are you on disability? How long?		
Are you a veteran?		

FAMILY MEMBERS (living in the home)

Spouse:_____ Age:_____

Child:_____ Age:_____

Child:_____ Age:_____

Child:_____ Age:_____

Child:_____ Age:_____

Income (monthly amount)	Gross	Net	Expenses (monthly)	Amt.
Guarantor			Mortgage / Rent	
Spouse			Utilities	
Dependents			Car Payments	
Public Assistance			Food / Groceries	
Food Stamps			Credit Cards	
Social Security			Medical Bill(s)	
Unemployment			Car Insurance	
Strike Benefits			Child Care	
Worker's Compensation			Medications	
Alimony			Other (please specify)	
Child Support				
Military Allotments				
Pensions				
Income from CDs, Rent, Dividends, Interest				
Total				

Texas Health Physicians Group

Name of Employer:_____
Telephone:_____
Employer Address:_____
Occupation:_____

Spouse's Employer:_____
Telephone:_____
Employer Address:_____
Occupation:_____

	Yes	No
Are you currently applying for Medicaid Benefits?		
Have you applied for assistance through your county hospital / indigent program?		
Are there any potentially liable third-parties responsible for your accident / injury / illness?		
Is anyone assisting you with payment of your medical bills?		
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 medical 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 Physicians Group may verify the financial information contained in this application and hereby authorize Texas Health Physicians Group 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 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.

I further understand that any financial assistance I receive shall not be construed as a waiver by Texas Health Physicians Group of its Texas Health Physicians Group lien for reimbursement of any amount I owe and that any reimbursement I receive relating to the Texas Health Physicians Group physician professional services must be sent to Texas Health Physicians Group.

_____ _____
Signature of Person Making Request, if Guarantor Date

_____ _____
Signature of Person Making Request, if Not Guarantor Relationship

_____ _____
Guarantor's Address City State Zip County Primary Telephone Number

Texas Health Physicians Group

Attachment D - THPG Financial Assistance Worksheet

ANY ONE OF THE FOLLOWING DOCUMENTS MAY BE REQUIRED TO BASE THE FINAL DETERMINATION OF PAYMENT AMOUNTS OR ANY ADJUSTMENT:

1. W-2 withholding statements for all employment during the relevant time-period.
2. Pay stubs from all employment for current month and two prior months.
3. An income tax return from the most recently filed calendar year; (first 2 pages only)
4. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance.
5. Forms approving or denying unemployment compensation.
6. Driver's license or identification card (in-order to identify the guarantor)
7. Written statements from employers or welfare agencies.

Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the guarantor. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.

HHS POVERTY GUIDELINES FOR 2022

2022 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
1	$13,590
2	$18,310
3	$23,030
4	$27,750
5	$32,470
6	$37,190
7	$41,910
8	$46,630
For families/households with more than 8 persons, add $4,720 for each additional person.	