Private Healthcare Facilities 902 Kitty Hawk Rd, Ste 170487 Universal City TX 78148-3825 866-996-2340

In accordance our Financial Assistance Policy, patients may apply for assistance to financially resolve current medical bills incurred by a Private Healthcare Facilities employed physician practice and/or hospital. A patient is approved for assistance based on the documented financial situation of the applying individual and their household, and the medical eligibility criteria outlined in the financial assistance policy.

PATIENT INFORMA	ATION:	1 7				
Patient name:		Social Security #:				
Date of Birth:	Patie	Patient's primary care physician:				
Address:	ress:Contact Phone:					
	State: _	Zip:	<u></u>			
Is the patient covered b	y any insurance? Yes	ible for the bill (guarantor)? sNo(if yes complete the INSUle to be covered by their employer, spou	URANCE	No		
If no, was insurance lost of Or child no longer covered		vent such as (job loss, marriage, divorce, e?	Yes _	No		
Patient's employer:		Employer phone:				
If patient is unemployed	d, last date of employ	ment:				
Can the patient answer	yes to any of the follo	owing questions:				
- Patient with any free clinic or indigent health access programs				No		
- Eligible for Medicaid spend-down program				No		
- Does the patient receive food stamps support				No No		
- Homeless				No		
- Declared bankruptcy	within the previous 12	months	165	110		
GUARANTOR INSU						
		Relationship to patient:				
		Group Number:				
Is the insurance policy	through an employer	? YesNo If yes, Employer Nam	ıe			
MUST A	TTACH A COPY OF	THE INSURANCE CARD TO THIS A	PPLICATIO	N		
(lis		NTOR HOUSEHOLD INFORMATION to usehold, their age, relationships to Guarantor and the second s	and employer)			
Legal Name	Age	Relationship to patient	Employer			
			_			
				_		

INCOME AND ASSETS:

(Please provide information on the income and assets of all the household members)

INCOME					
Source of Income	Who's Income?	Monthly gross			
Wages from employer					
Rental property income					
Trental property income					
Social Security					
,					
Alimony/Child Support					
Unemployment					
Other retirement					
	TOTAL INCOME:				
CASH ASSETS					
Source of Cash Assets	Who's Cash Asset?	Total amount of cash asset			
Checking					
Savings					
Stocks/bonds/CDs					
401K					
401K					
	TOTAL CASH ASSETS:				
When submitting a financial assistance application, the follow	ving documentation mus	<u>t be provided:</u>			
• Government issued photo ID (for example: driver's license)					
 Valid insurance card - if the patient is covered by insurance Most current paycheck statement with YTD earnings, or written verification of wages from employer, or 					
 Most current paycheck statement with YTD earnings, or writer public welfare, unemployment benefits, or governmental agreement. 		rom employer, or			
<u>Statement of understanding and agreement</u> : The information I am providing is true and accurate to the best of my knowledge. I will apply and assist in the application process for any governmental assistance (Medicare, Medicaid, Affordable Health Care Act). I					
only utilize Private Healthcare Facilities Financial Assistance as a means of last resort. If any information I provide proves to be					
untrue, Private Healthcare Facilities may reevaluate my financial assistance status and take what action is deemed appropriate.					
Signature of Patient		Date			
Orginature of Fatigrit		Date			
Signature of Guarantor (if different than patient)		Date			