Baylor Scott & White Health
Financial Assistance Application

Patient Account Number

Patient Name (Last, First, MI) Social Security Number

Patient's Residential Address City State Zip Code County

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Birth Date (Month/Date/Year) Telephone Number

Spouse's Name

Employed ☐ Yes ☐ No

Patient's Employer

Telephone #

Employed ☐ Yes ☐ No

Spouse's Employer

Telephone #

Are the BSWH facilities you received services at the closest in network facilities to your primary residence? ☐ Yes ☐ No

If no, were the closest facilities unable or unwilling to provide your care? ☐ Yes ☐ No

*****If unemployed, please include the previous employer's name and telephone number*****

A. *Income:* Please provide the income for each of the following persons in your household.

Patient ☐ Full Time ☐ Part Time - Hours/Week =_____
$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$ _____ **Additional Income**

Spouse ☐ Full Time ☐ Part Time - Hours/Week =_____
$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$ _____ **Additional Income**

Total Household Income $ _____

Please complete only if patient is a minor (if not leave blank)

Patient's Father ☐ Full Time ☐ Part Time - Hours/Week =_____
$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$ _____ **Additional Income**

Patient's Mother ☐ Full Time ☐ Part Time - Hours/Week =_____
$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$ _____ **Additional Income**

Total Household Income $ _____

B. *Income Verification:* Please provide verification ***(send only copies, no original documentation)*** for all sources of household income (acceptable documentation listed below). Check attached documents:

☐ Paycheck Remittance ☐ Employer Verification ☐ Credit Inquiry (completed by BSWH)
☐ IRS Form W-2 ☐ Tax Return ☐ Governmental Assistance (food stamps, CDIC, Medicaid, TANF)
☐ Bank Statements ☐ Other (describe below) ☐ Social Security, Workers Compensation or Unemployment Compensation Determination Letters

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

_____

C. *Family Members:* **Please provide the total number of people in the patient's household.**
(This number should only include the patient, patient's spouse, and the patient's dependents)

D. *Assets and Other Resources:*

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

I understand Baylor Scott & White Health ("BSWH") may verify the financial information contained in this Financial Assistance Application ("Application") in connection with BSWH'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 BSWH 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.

I further understand that some physicians and providers may not be employees of BSWH. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

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

For Hospital Use Only

☐ Application information obtained by BSWH Employee in person or over the phone, no patient signature required.

Electronic Signature of BSWH Employee or BSWH Representative Date

Notes Regarding Income Verification/Number in the Household:

☐ Patient is part of community care program Program Name _____ First Statement Date: _____