HOUSTON Methodist LEADING MEDICINE

Financial Assistance Application

Instructions: Please fill in all the blanks below. If an item is not applicable, please write N/A. Attach photocopies of the following that apply to your current situation: **1. Most recent paycheck stub(s) that reflects YTD income information; 2. Most recent income tax return, including all attachments; 3. Social Security check or entitlement letter or bank statement, if direct deposit; 4. Unemployment award letter; 5. Harris Health System gold card.** If unemployed and dependent on others for income and/or living expenses, please attach a letter of support and a copy of the tax return, if listed as a dependent on the tax return**. If you have questions or need additional assistance in filling out this application, please contact the Centralized Business Office at 877-493-3228 M-F 7am – 7pm, Saturday 8am-12pm.**

Please return completed application and supporting documents to any Patient Access team member, or fax to (832) 667-5995 or by mail to: Houston Methodist, Centralized Business Office; Attn: Financial Assistance Unit; 701 S. Fry Road; Katy, TX 77450.

_______________________________________ PATIENT NAME (PLEASE PRINT)

_______________________________________ PATIENT SOCIAL SECURITY NUMBER

_______________________________________ PATIENT'S SPOUSE/GUARDIAN NAME (PLEASE PRINT)

_______________________________________ PATIENT'S SPOUSE/GUARDIAN SOCIAL SECURITY NUMBER

HOME ADDRESS ____

PHONE NUMBER ____________________ DATE OF BIRTH _______________ MARITAL STATUS ___________________________

CLINICAL SERVICE(S) REQUESTED: ____

ACCOUNT NUMBER: ________________________________ SERVICE DATES:____

No. of children under 18 years living at home: _______________

Names of Dependents

Directly related _______________ ____

Step-children _______________ ____

Not related _______________ ____

Guardian of _______________ ____

Patient	Spouse/Other
Employer ________________________________	Employer ________________________________
☐ Employed Full-time	☐ Employed Full-time
☐ Employed Part Time	☐ Employed Part Time
☐ Unemployed/retired/disabled	☐ Unemployed/retired/disabled
☐ Unable to return to work	☐ Unable to return to work
☐ Housewife	☐ Housewife

TOTAL FAMILY INCOME* $____________________/month **(SEND PROOF(S) OF INCOME WITH APPLICATION)**

** Includes all wages, farm or self-employment, public assistance, Social Security, unemployment/worker's compensation, retirement, strike benefits, alimony, child support, military allotments, pensions, incomes from dividends, interest, rental property and other miscellaneous income sources.*

I certify that the above information is true and accurate to the best of my knowledge. It is understood that failure to provide all of the information requested above may be considered as a disqualification from any financial relief under the Program. Further, if applicable, I will make application for governmental assistance, take appropriate action to obtain such assistance and advise HM of the outcome of my application. I (we) give HM consent to obtain information from any source to verify the statement(s) that I (we) have made.

_______________________________________ Patient Signature

_______________________________________ Date