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 7a – 7p, Saturday 8a-12p.**

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) SOCIAL SECURITY NUMBER

_____ _____
SPOUSE/PARENT/GUARDIAN NAME (PLEASE PRINT) SOCIAL SECURITY NUMBER

HOME ADDRESS _____

PHONE NUMBER _____ DATE OF BIRTH _____ MARITAL STATUS _____

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 _____ _____

MONTHLY EXPENSES

Housing:
Rent
Own
Paid
Monthly payment $_____

Utilities:
Electricity $_____
Water $_____
Gas $_____

Automobiles:
Own/# _____
Lease/# _____
Monthly payment $_____

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.*

BANK ACCOUNTS/OTHER ASSETS:

Checking Account	**Yes**	**No**	**Balance**	**$** _____
Savings Account	**Yes**	**No**	**Balance**	**$** _____
Stocks/Bonds, Etc.	**Yes**	**No**	**Balance**	**$** _____
Additional Property	**Yes**	**No**	**Describe**	_____

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/Applicant's Signature) **(Date)**

Please complete this side only. **Rev. 10/2015**