Baylor Scott & White Health
Financial Assistance Application

Patient Account Number

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

Patient Address | City | State | Zip Code

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 # ______________________

Other Baylor Scott & White Health accounts for your household with an unpaid balance (Please list patient's NAME, DOB and FACILITY NAME)

*****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:

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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? ☐ Yes ☐ No If Yes, current amount available: $_________
(Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)

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 ____

Baylor Scott & White Health
Financial Assistance
2001 Bryan Street
Suite 2600
Dallas, TX 75201

Dear Patient/Guarantor:

As part of our commitment to serve the community, Baylor Scott & White Health provides financial assistance to individuals who satisfy certain income requirements. Your cooperation will provide us with the information to process your request. To determine if you qualify for financial assistance, we require the following:

☐ **Proof of Income**
Verification of income is required for patient and spouse (if applicable), or patient's parent(s) if the patient is a minor. Please provide a copy of at least one of the following (listed in order of preference): an IRS Form W-2, Wage and Tax Statement; paycheck stub remittance; individual tax return; proof of participation in a governmental assistance program such as food stamps, CDIC, Medicaid or TANF; letter from employer confirming employment and income Social Security Statement of Benefits, workers' compensation, or unemployment compensation determination letters; or bank statements. If you are unable to provide one of the sources of income documentation listed above, please explain on the application why this information is not available.

☐ **Outstanding Medical Bills**
Copies of all unpaid Baylor Scott & White medical bills. Medical bills eligible for consideration include physician bills, radiology bills, other facility bills, anesthesiologist bills, etc. Other medical bills from non-BSWH providers may be considered as long as they are related to the episode of care for the same date(s) of service.

☐ **Completed Financial Assistance Application**
A completed Financial Assistance Application is required for consideration to receive financial assistance. Please ensure the entire form is complete, including "Section C: Family Members" as follows:

- If patient is a minor: Include patient, patient's mother and father, and dependents of the patient's mother and father.
- If patient is an adult: Include patient, patient's spouse (if applicable) and any dependents.

This is your only notice. You must return the information outlined above or we cannot consider your account for financial assistance and payment is required. If the requested financial assistance information or payment is not received, we will evaluate your account for placement with a collection agency or if your account is already with a collection agency, it will remain with the collection agency. This could include reporting this debt to the credit bureaus. Prompt action will protect your credit rating.

For any questions, please contact Customer Service at 1-800-725-0024, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

Your completed Financial Assistance Application and required supporting documentation can be faxed to 214-818-9345 or mailed to:

Baylor Scott & White Health
Attn: Financial Assistance
2001 Bryan Street Suite 2600
Dallas, TX 75201

Thank you for your prompt attention to this matter. Submission of the above documentation does not guarantee approval for financial assistance.

Sincerely,

Baylor Scott & White Health
Financial Assistance