USMD Health System | Hospital at Arlington
801 West Interstate 20
Arlington, Texas 76017
817.472.3400
charityapplication@usmd.com

USMD Health System | Hospital at Fort Worth
5900 Alta Mesa Blvd.
Fort Worth, Texas 76132
817.433.9100
charityapplication@usmd.com

Date:______________Guarantor Name: ____

Patient Name:________________________________Date of Service: ______________

Hospital Account #____________________________Medical Record # _____________

☐ USMD Hospital at Arlington ☐ USMD Hospital at Fort Worth

Dear Patient:

Attached you will find the USMD Health System Charity Care Program Application. Completion of this application will enable us to present your account for consideration of financial assistance for your hospital bill(s). This is for your hospital charges only.

We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential information. It will only be shared within USMD on a need to know basis.

Please complete each item on the application. If you need additional space for any explanations, please utilize the back of the application.

Please provide copies of your current month and two prior months' pay stubs and/or proof of any other form of income for the household. If you do not receive check stubs, please provide copies of your bank statements showing your monthly deposits. If self-employed, please provide a copy of your most recently filed personal income tax return and a current profit and loss statement.

Failure to provide the requested documentation can result in a denial for charity consideration.

It is extremely important that you complete this application upon receipt and return it to **charityapplication@usmd.com** within 15 days from the date of this letter.

If you have difficulty completing this application or there is an area that is unclear, please call. Your cooperation is appreciated.

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APPLICATION FOR CHARITY CARE ASSISTANCE – Page 1

Patient Name: Last: ______________________ First: ______________________ MI: ________

Social Security #______________________ DOB:______________ Hospital Account #: ______________________

Married__________ Single__________ Divorced__________ Widowed__________ Separated __________

Do you have minor children (under 18)?	________Yes	________No
Do they live with you?	________Yes	________No
Are they your birth/legally adopted children?	________Yes	________No
Patient Employed?	________Yes	________No
Spouse Employed?	________Yes	________No
Do you have medical insurance?	________Yes	________No
Are you on disability? How long? __________	________Yes	________No
Are you a veteran?	________Yes	________No

FAMILY MEMBERS – (Living in the home)

Spouse: ______________________________

Child: ______________________ Age ______ Child: ______________________ Age ______

Child: ______________________ Age ______ Child: ______________________ Age ______

INCOME (Monthly Amount):

	Gross	Net
Patient	$__________	$__________
Spouse	$__________	$__________
Dependents	$__________	$__________
Public Assistance	$__________	$__________
Food Stamps	$__________	$__________
Social Security	$__________	$__________
Unemployment	$__________	$__________
Strike Benefits	$__________	$__________
Worker's Compensation	$__________	$__________
Alimony	$__________	$__________
Child Support	$__________	$__________
Military Allotments	$__________	$__________
Pensions		
Income from: CD's Rent, Dividends, Interest	$__________	$__________
TOTAL:	$__________	$__________

Expenses	Monthly Amount
Mortgage/Rent	$__________
Utilities	$__________
Car Payments	$__________
Food/Groceries	$__________
Credit Cards	$__________
Other (please specify) ______________	$__________
TOTAL:	**$**__________

ASSETS

Checking Account	$ ______________________
Savings Account	$ ______________________
CD's, IRA's	$ ______________________
Other Investments (Stocks, bonds, etc.)	$ ______________________
Properties/Land other than primary residence	$ ______________________

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APPLICATION FOR CHARITY CARE ASSISTANCE – Page 2

Name of Employer ______________________________ Spouse's Employer ______________________________

Telephone # ______________________________ Telephone # ______________________________

Employer Address ______________________________ Employer Address ______________________________

Occupation ______________________________ Occupation ______________________________

Are you currently applying for Medicaid Benefits? _____ Yes _____ No

Have you applied for assistance through your county hospital/indigent program? _____ Yes _____ No

Is your physician donating his/her services? _____ Yes _____ No

Are there any potentially liable third-parties responsible for your accident/injury/illness? _____ Yes _____ No

Is anyone assisting you with payment of your hospital bills? _____ Yes _____ No

If yes, who is assisting you? __________________

How much assistance are you receiving? __________________

List any other information you feel would be helpful to us in determining your eligibility for assistance in paying your hospital bill.

____

____

____

Expected earnings and/or funds you will receive during your time off due to your illness (Sick leave, paid time off, short/long term disability income). $ __________________

Expected length of time you will be unable to work and/or earn wages: __________________

I understand that USMD may verify the financial information contained in this application in connection with the hospital's evaluation of this application, and hereby authorize the hospital to contact my employer to certify the information provided and to request reports from credit reporting agencies. I am aware that this information will be used to determine my eligibility for charity assistance, and that the falsification of information in this application may result in denial of charity care assistance. I also understand that any charity approval may be completely or partially reversed in the event of a recovery from a third-party or other source.

I further understand that any charity care I receive shall not be construed as a waiver by hospital of its hospital lien for reimbursement of any amount I owe, and that any reimbursement I receive relating to this hospitalization must be sent to USMD.

______________________________ ______________________________

Signature of Person Making Request, If Patient Date

______________________________ ______________________________

Signature of Person Making Request, If Not Patient Relationship

______________________________ ______________________________

Patient's Address City State Zip County Home Telephone Number