NTMC
North Texas
Medical Center

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

SCREENING INFORMATION:

- Complete questions to allow our patient navigators to assist in the best financial assistance course.

APPLICANT INFORMATION:

- Print your full legal name.
  - If you are completing this application for someone other than yourself, write the full legal name and social security number* of the patient for whom this application is being completed.
- Write your home and work telephone number and give a daytime telephone where you can be reached most often.
- Write your current address and which country you presently live in.

FAMILY INFORMATION:

- Print the names of everyone in your household along with their ages, whether they have income or not.
- Include yourself, other related and unrelated people in your household. (use another piece of paper if you need more space.)

INCOME INFORMATION:

- Write the amount of income each household member received last month, before taxes or anything else is taken out, and where it came from, such as earnings, welfare, child support, social security and other income.
- ALL APPLICANTS SHOULD ATTEMPT TO PROVIDE PROOF OF ANY OF THE FOLLOWING TO VERIFY INCOME:
  - Wage and Earnings Statement Paycheck Remittance and/ or Individual Tax Return
  - Social Security, Workers Compensation or Unemployment Compensation letter
  - Proof of eligibility for Government Program
  - You may also verify your income by: (a) having your employer provide written verification; (2) having your employer speak with a Hospital representative; or (3) providing a written or verbal statement to the Hospital representative verifying your gross annual household income.
- If you are unable to provide one of the sources of income documentation listed above, please provide a written explanation in the INCOME VERIFICATION section of the Financial Assistance Application.

EXPENSES INFORMATION:

- Write the usual amount of household expenses.

ASSET OR RESOURCE INFORMATION*:

- Complete the questions on application.

ADDITIONAL INFORMATION:

- Complete questions to allow our patient navigators to assist the entire household in the best financial assistance course.

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SIGNATURE:

- ➢ All applications should have the signature of the applicant or responsible party (unless medical problems or situations, i.e. isolation, I.C.U., etc. are certain.). If it is not possible or feasible to obtain a signature, please explain to hospital staff why signature is unavailable.

ELIGIBILITY DETERMINATION:

- ➢ Eligibility will be determined based on Poverty Income Guidelines.
- ➢ Approved applications cover charges at North Texas Medical Center and clinics of North Texas Medical Center.
- ➢ Additional information may be required to determine your eligibility, depending upon the program for which you are applying.

What does financial assistance cover? Financial assistance covers medically necessary services provided by North Texas Medical Center or NTMC Complete Health Care, depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by NTMC specialists or other organizations.

If you have questions or need help completing this application: Our financial assistance policies, information about the program and application materials are available on our website at www.ntmconline.net. You can obtain help by contacting customer service at (940) 612-8389 Monday - Friday 8:00 am to 4:30pm.

Mail completed application with all documents to: NTMC, 1900 Hospital Blvd, Gainesville, Texas 76240 or take to North Texas Medical Center or NTMC Health Complete Care clinic.

In order for your application to be processed, you must provide:

- Information about your family
- Information about your family's gross monthly income, with income source verification required:
  - Employment pay stub
  - Recent tax return
  - Proof of any other income listed
- Declare assets*
- Sign and date financial assistance form.

Once an application is received, we may check all the information and may ask for additional information. We will notify you of the final determination of eligibility within 14 business days of receiving a complete financial application, including documentation of income or additionally requested information.

All areas with an asterisk (*) are optitionall information for applicants applying for the Sliding Fee Discount Program at NTMC Health Complete Care, only. The other financial assistance programs require this information.

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SCREENING INFORMATION
Has the applicant applied for Medicaid? ◯ Yes ◯ No
Does the applicant receive state public assistance such as Food stamps or housing? ◯ Yes ◯ No
Is the applicant currently homeless? ◯ Yes ◯ No
Is the applicant's medical care need related to a car accident or work injury? ◯ Yes ◯ No

APPLICANT INFORMATION	
Applicant Name:	Social Security Number:
Home Phone #:	Work Phone#:
Address:	City/State/Zip Code:
What County do you live in?	Is Address Permanent or Temporary?
Employment Status ▢ Employed ☐ Self-Employed ☐ Unemployed (how long unemployed: _____) ▢ Student ☐ Disabled ☐ Retired ☐ Other (_____)	

FAMILY INFORMATION				
Name of other Household members	Social Security Number *	Date of Birth	Sex	Relationship to Applicant

INCOME INFORMATION			
All family member income must be disclosed. Sources of income include, for example: - Wages - Self-Employment - Unemployment - Workers compensation -Disability -SSI -Child/ spousal support -Work study programs (students) - Pension -Retirement account distributions -Other (please explain)			
Name of Person Receiving Money	Name of Agency, Person or Employer Providing Money	Amount Received	How Often Received
REMEMBER: You must include proof of income with your application. If you can not provide documentation, you may submit a statement describing your income. If you have no income, please submit a statement with an explanation.			

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EXPENSE INFORMATION			
Rent/ Mortgage	$	Tax & Insurance on Home	$
Utilities (electric, gas, water)	$	Medical and/ or medications	$
Telephone/ Cell Phone	$	Child care	$
Cable/ Satellite		Other debt/loans	
Transportation(gas, car payment, bus, taxi)	$	Other:	$
Do you live with someone else? ◯ Yes ◯ No			
Does anyone pay these household expenses for you? ◯ Yes ◯ No If Yes, who pays? _____			

ASSET/ RESOURCE INFORMATION *	
Current checking account balance $_____ Current savings account balance $_____	Does your family have these other assets? **Please check all that apply** ▢ Stocks ☐ Bonds ☐ 401K ☐ Health Savings Account ☐ Trust(s) ▢ Property (excluding primary residence) ☐ Own a business
How many cars, trucks, or other vehicles do you and anyone in your household have? List year, make and model below:	

	Year	Make and Model
1		
2		
3		

ADDITIONAL INFORMATION
Is applicant or anyone in your household pregnant? ◯ Yes ◯ No If Yes, who? _____
Is applicant or anyone in your household disabled? ◯ Yes ◯ No If Yes, who? _____
Has applicant or anyone in household applied for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)? ◯ Yes ◯ No If Yes, who? _____
Does applicant or anyone in the household have health care coverage (Medicare, health insurance, Veterans Affairs, Tricare, ect.)? ◯ Yes ◯ No If Yes, who? _____
Does the applicant or anyone in the household have unpaid health care bills from North Texas Medical Center and/ or NTMC Complete Health Care from the last three months? ◯ Yes ◯ No If Yes, who? _____

I certify that all of the above is true and correct and that all income is reported. I understand that this information is being given for the determination of financial assistance for services rendered at North Texas Medical Center; and that hospital officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to immediate denial.

X _____ _____

SIGNATURE OF APPLICANT OR RESPONSIBLE PARTY DATE

*Optional information for applicants applying for Sliding Fee Discount Program at NTMC Health Complete Care, only. Other financial assistance programs require information.