BaylorScott&White HEALTH

BAYLOR SCOTT & WHITE HEALTH FINANCIAL ASSISTANCE APPLICATION

Effective 1/1/2025 Rev. 11/2024

PLEASE ENTER THE ACCOUNT NUMBER(S) LISTED ON YOUR STATEMENT(S):	MEDICAL RECORD NUMBER (MRN):

PATIENT DEMOGRAPHICS

Patient's Name (Last, First, MI)	Social Security Number	Date of Birth (Month/Date/Year)

Patient's Residential Address (Street, City, State, Zip Code)	County

Patient's Phone	Marital Status ☐ Separated ☐ Divorced ☐ Married ☐ Single ☐ Widowed	Spouse's Name

EMPLOYMENT **Applications for minor patients require total household income**

	PATIENT OR RESPONSIBLE PARTY EMPLOYMENT *If the patient is a minor: mother, guardian, or stepparent*	SPOUSE OR OTHER RESPONSIBLE PARTY EMPLOYMENT *If the patient is a minor: father, guardian or stepparent*
Employment Status	☐ Full-Time ☐ Part-Time ☐ Unemployed - *Please include the previous employer's name and telephone number.*	☐ Full-Time ☐ Part-Time ☐ Unemployed - *Please include previous employer's name and telephone number.*
Employer		
Employer Phone Number		
Hours Worked Per Week	_____ **Frequency** ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually	_____ **Frequency** ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
Frequency	☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually	☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
Income Earned	$	$
Additional Income	$	$

Patient's Total Household Income: $_____ (Total of all income listed above)

Income Verification: Please provide verification (send only copies, no original documentation) for all sources of household income.

☐ Paycheck Remittance
☐ Employer Verification
☐ Credit Inquiry (completed by BSWH)
☐ IRS Form W-2
☐ Tax Return
☐ Governmental Assistance (food stamps, CDIC, Medicaid, TANF)
☐ Bank Statements
☐ Social Security, Workers, Compensation or Unemployment Compensation Determination Letters
☐ Other:_____

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

FAMILY MEMBERS: Please provide the total number of people in the patient's household. This number should only include the patient, the patient's spouse, and the patient's dependents.

ASSETS AND OTHER RESOURCES

Do you have any assets or other resources available to you? (Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.) ☐ Yes ☐ No If Yes, current amount available: $	Do you have medical insurance? ☐ Yes ☐ No If Yes, please list insurance 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. Signature of BSWH Employee / BSWH Rep: _____Date: _____	☐ Patient is part of community care programs Name of Program: _____