Financial Assistance Application

Instructions: All fields must be completed unless noted otherwise. **Medical Record Number**: _____

Patient Information

Last Name, First Name

_____

Date of Birth

_____

Street Address

_____

City, State, Zip Code

_____

Social Security Number

_____

Home Phone Number

_____

Alternate Phone Number

_____

Guarantor Information

Last Name, First Name

_____

Date of Birth

_____

Source of Income

_____

Last 12 Months of Annual Household Income

_____

Social Security Number

_____

If income is $0, please select one of the following:

- Disabled
- Homeless
- Lives with friend(s)
- Lives with relative(s)
- Retired
- Unemployed

Number of People in Household

_____

Number of Children Under Age 21 in the Home

_____

Vehicles in Household including Cars/Boats/RV

_____

Checking/Savings Account Balances

_____

AdventHealth

Texas Health Huguley Hospital® FORT WORTH SOUTH

Texas Health Hospital® MANSFIELD

Financial Assistance Application

Properties Owned and Values

_____

CD/Retirement/Investment Account Balances

_____

Other Assets

_____

Please read before signing. I CERTIFY that the information I have provided is true and accurate to the best of my knowledge. I will independently or with the assistance of hospital personnel apply for ANY and ALL ASSISTANCE which may be available through federal, state, local government and private sources to help pay this hospital bill. I understand that if I do not cooperate with my hospital provider in providing requested information, my application may be denied for possible financial assistance. I hereby grant permission and authorize any accredited agent of the Medicaid program to disclose to my hospital provider ALL information regarding the status of my Medicaid application and if the application is not approved and the reason for disapproval. I will ASSIGN to my hospital provider ALL FUNDS received from the above sources, which are provided to help with this HOSPITAL BILL. I, on my own behalf, and for my immediate family member(s), authorized representative(s), physician(s), counselor(s) (including clergy), and attorney(s), agree to hold and maintain in strictest confidence any written communication and/or oral discussions between me and my hospital provider regarding matters relating to services provided to me by my hospital provider. I understand that the information which I submit is subject to verification by my hospital provider, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I AUTHORIZE my employer to release to my hospital provider my proof of income. I UNDERSTAND that if any information I have given proves to be untrue, my hospital provider will reevaluate my financial status and take whatever action becomes appropriate. **To qualify for assistance, at least one piece of supporting documentation that verifies household income may be required. Supporting documentation can include, but is not limited to, most recent year's tax return, a current W-2, notarized letter of support, etc. Requests for assistance may be denied if supporting documentation is not provided. Any unpaid balance will be eligible for further collection action.** [State of Florida Applicants: Florida Statute s.817.50 (1). Whoever shall, willfully and with intent to defraud, obtain or attempt to obtain goods, products, merchandise or services from any hospital in this state shall be guilty of a misdemeanor of the second degree, punishable as provided in s.775.082 or s.775-083.]

Signature of Applicant / Guarantor

_____

Date Completed

_____

How to Submit Your Application

Mail	AdventHealth, Attn: Financial Assistance, PO Box 935979, Atlanta, GA 31193
Email	Financialassist@medsrv.co (only two letters after the period in the email address)
Patient Portal	https://account.adventhealth.com/login or AdventHealth App
Questions?	800-462-0490

AdventHealth

Texas Health Huguley Hospital FORT WORTH SOUTH

Texas Health Hospital MANSFIELD