Summary of Financial Assistance Policy For Methodist Hospital & Methodist Children's Hospital, Methodist Hospital | Specialty and Transplant, Methodist Hospital | Metropolitan, Methodist Hospital | Texsan, Methodist Hospital | Northeast, Methodist Hospital | Stone Oak, Methodist Hospital | Atascosa, Methodist Hospital | Hill Country, Methodist Hospital | Landmark, Methodist Hospital | Westover Hills

As part of our mission, Methodist Healthcare provides care to patients without financial means to pay for hospital services. Care will be provided to all patients who present themselves for care at any Methodist Healthcare facility without regard to race, creed, color or national origin and who are classified as financially or medically indigent.

A financially indigent person is one who is uninsured or underinsured and is accepted for care with no obligation or discounted obligation to pay for services based on income and family size. The hospital uses poverty income guidelines issued by the U.S. Department of Health and Human Services to determine a person's eligibility for charity care.

A medically indigent patient is a person whose medical and hospital bills after payment by third party payers exceeds 10 percent of the person's annual gross income and the person is unable to pay the remaining bill. Methodist Healthcare may consider other financial assets and liabilities of the patient when determining ability to pay.

Financial assistance with respect to emergency and medically necessary care may be available to patients who do not qualify for state or federal assistance. In most cases, patients that fall below 200 percent of the federal poverty guidelines based on total household income may receive 100 percent of their bill forgiven (subject to income verification/documentation requirements). In certain cases, other discounts ranging from 40 to 90 percent may apply if the patient's total household income is over 200 percent and not more than 500 percent of the federal poverty guidelines.

Further eligibility and assistance information, a free copy of our financial assistance policy, the financial assistance application form and a plain language summary of the financial assistance policy (in either English or Spanish) are available by written request to the following address:

Texas Shared Service Center
PO Box 292369
Nashville, TN 37229-2369

or you may go to our website at: www.sahealth.com and click on "Charity Care."

You may apply for financial assistance by completing the application referenced above and submitting it at the address above.

If you are eligible for financial assistance, the amount charged for emergency or other medically necessary care will not exceed amounts generally billed to patients with insurance.

Additional information concerning Methodist Healthcare's financial assistance program and how to apply for financial assistance can be obtained from the business office at:

Texas Shared Service Center
PO Box 292369
Nashville, TN 37229-2369

Or, you can call each location at:

• Methodist Hospital	866-391-2019
• Methodist Children's Hospital	866-391-2019
• Methodist Hospital | Texsan	866-291-3650
• Methodist Hospital | Specialty and Transplant	866-391-2013
• Methodist Hospital | Metropolitan	866-391-2014
• Methodist Hospital | Northeast	866-391-2016
• Methodist Hospital | Stone Oak	866-329-9475
• Methodist Hospital | Atascosa	855-890-3305
• Methodist Hospital | Hill Country	844-919-3881
• Methodist Hospital | Landmark	833-839-7148
• Methodist Hospital | Westover Hills	844-608-2321

Patient/Representative Signature: _____

Date: _____

Witness Signature: _____

Date: _____

Citizenship Form

Please select which of the following statements are true:

- ◯ I am a United States citizen.
- ◯ I am lawfully present in the United States.
- ◯ I am not lawfully present in the United States.
- ◯ I decline to respond.

Please note that your response to the above question will not affect your patient care.

Signature: _____

Date: _____

Place Label Here:

Not Part of Permanent Medical Record, Forward Original Copy to Patient Access

Patient Name:_____ **Account Number:**_____

Uninsured Patient Information Document

This document is intended to help provide uninsured patients with an understanding of the financial aspects of their healthcare. Services shall be provided in the same manner and of the same quality regardless of a person's ability to pay. Patients covered by automobile, third party liability or other reimbursement that may be billed for these services, will not qualify for the uninsured discount.

This document also provides options available to assist you in resolving your account. In an effort to assist uninsured patients, HCA will apply a discount to your account and then will work with you to resolve your remaining account balance.

The following information is an outline of how an uninsured account will be processed and the discount options that may be available to you. If you have received an elective cosmetic or flat rate procedure, these discounts do not apply. Otherwise, HCA discounts all uninsured bills. The discounted balance due on the account is expected to be paid in full at the time of service.

- Total charges for services provided are applied to the account.
- Uninsured discount is applied to total charges, thereby reducing the account balance.
- If you are unable to pay the discounted account balance in full, we will work with you to establish monthly payment arrangements.
- If you cannot establish monthly payment arrangements, we will assist you with applying for Medicaid assistance.
- If you obtain Medicaid we will bill them and you will only be responsible for any non-covered charges.
- If you do not qualify for Medicaid, you may complete the Financial Assistance Application, provide supporting documentation as needed and have this visit reviewed for a potential Charity discount.
- If you qualify for a Charity discount based upon Federal Poverty Guidelines, your account will be considered paid in full. If you do not meet the required Federal Poverty Guidelines, you will need to make arrangements to resolve your bill immediately.
- You are aware that by representing that there is no insurance, the facility is relying on your representation. You agree that if an uninsured discount is applied to your account and insurance is available, the uninsured discount will be rescinded and the account balance adjusted accordingly so that full payment is required.

HCA provides a 100% discount on approved charity accounts. All other uninsured accounts will receive a partial discount.

_____	_____	_____
Patient/Responsible Party Signature	Date	Time
_____	_____	_____
Witness Signature	Date	Time

Methodist Healthcare System Financial Assistance Application

Patient Name | Patient Account Number

Telephone Number | Social Security Number | Birth Date (Month/Day/Year)

☐ Employed

☐ Unemployed

Employer (Name, Address and Telephone Number)

Spouse Name | Social Security Number | Birth Date (Month/Day/Year)

Patient's Father (If patient is a minor) | Social Security Number | Birth Date (Month/Day/Year)

Patient's Mother (If patient is a minor) | Social Security Number | Birth Date (Month/Day/Year)

A. *Wages:* Please provide the wages for each of the following persons in your household.

		Circle One						Circle One
Patient	$_____	Hr/ ☐	Wk/ ☐	Month/ ☐	Year ☐	Patient's Father (if patient is a minor)	$_____	Hr/ ☐ Wk/ ☐ Month/ ☐ Year ☐
Spouse	$_____	Hr/ ☐	Wk/ ☐	Month/ ☐	Year ☐	Patient's Mother (if patient is a minor)	$_____	Hr/Wk/ ☐ Month/ ☐ Year ☐

B. *Other Resources:* Please provide the total amount of other resources available to you, including savings accounts, checking accounts, stocks, bonds, etc. $_____

Please provide the amount of yearly income you receive from these other resources, including interest income, dividends, rental income, etc. $_____

C. *Family Members:* Please provide the number of persons in the patient's household.

D. *Income Verification:* Please provide any of the following types of documentation to verify your income.

- IRS Form W-2
- Paycheck Remittance
- Tax Return
- Bank Statements
- Employer Verification
- Proof of Participation in Governmental Assistance programs such as food stamps, CDIC, Medicaid or AFDC
- Social Security or Unemployment Compensation Determination Letters
- Other, Please Describe _____

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

_____

I understand Methodist Healthcare System (MHS) may verify the financial information contained in this Financial Assistance Application ("Application") in connection with MHS' evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize MHS to request reports from credit reporting agencies and the Social Security Administration. I certify that this information is true to the best of my knowledge and I am aware that falsification of information on this Application may result in denial of financial assistance.

I understand that any financial assistance is based on my inability to pay and that if any new source of income becomes available,

_____ Date_____

Signature of Patient or Responsible Party

MHS may reverse its grant of financial assistance in whole or in part.

_____ Date_____

MHS Employee Signature if any part of Financial Assistance Application Completed by an MHS Employee

Methodist Healthcare System Financial Assistance Application Information and Instructions

Instructions:
As part of its commitment to serve the community and in fulfilling one of the charitable purposes of Methodist Healthcare Ministries Methodist Healthcare System elects to provide financial assistance to individuals who satisfy certain income requirements.

To determine if a person may qualify for financial assistance, we need to obtain certain financial information as outlined within this application. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please complete the Financial Assistance Application and return the completed form to the Registration Representative, or the completed form may be mailed to the following address:

Texas Shared Service Center
PO Box 292369
Nashville, TN 37229-2369

Once the application has been reviewed and processed, we will notify you of the decision. If you are eligible for financial assistance, you may request information describing the process Methodist Healthcare System uses to calculate the amount due. The amount due will not exceed amounts generally billed to patients with insurance as determined by using the look back methods described in Internal Revenue Service regulations. Requests for this information should be submitted to:

Texas Shared Service Center
PO Box 292369
Nashville, TN 37229-2369

Section A: Wages
In Section A of the Financial Assistance Application, please indicate the Dollar Amount each listed person receives as compensation and whether the amount represents hourly, weekly, monthly, or yearly compensation.

Section B: Other Resources
In the first blank in Section B of the Financial Assistance Application, please indicate the Dollar Amount you have invested in checking accounts, savings accounts, stocks, etc. In the second blank please indicate the Dollar Amount of income you receive yearly from such investments. For example, in the first blank one might put that they have $5,000 in a savings account and in the second blank they might put that they earn $250 interest yearly on that account.

Section C: Family Members
Section C of the Financial Assistance Application requests information on the number of persons in the patient's household. This number should include the patient, the patient's spouse and the patient's dependents. If the patient is a minor, please include the patient, the patient's mother and/or father and/or legal guardian and any Resident Dependents of the patient's mother and/or father, and/or Legal Guardian.

Section D: Income Verification
In order to consider your request for financial assistance, verification of the wages reported in Section A of the Financial Assistance Application is required. Please provide a copy of an IRS Form W-2, Wages and Tax Statement; pay check remittance; tax return; bank statement or other appropriate indicator of income ***or*** proof of participation in a public benefit program such as Social Security, Unemployment Compensation, Medicaid, County Indigent Health Program, AFDC, Unemployment Insurance, Food Stamps, WIC, Texas Healthy Kids, Children's Health Insurance Program, or other similar indigency related programs.

You may also verify your wages by having your employer provide written verification or by having your employer speak with an MHS representative.

If you are unable to provide one of the sources of income documentation listed above, please provide a written explanation in Section D of the Financial Assistance Application.

Physician Services
The physicians providing services are not employees of Methodist Healthcare System. You will receive separate bills from your private physician and from other physicians whose services you required. For questions regarding these bills, or to make payment arrangements for physician services, please contact the individual physician's office.