Financial Assistance Application

Thank you for choosing PAM Rehabilitation Hospital of Round Rock. It is the policy of PAM Rehabilitation Hospital of Round Rock to offer financial assistance to patients who either do not have health insurance or are underinsured and may be not be able to pay in full for their health care based on their income, assets and needs.

If you are unable to pay for the medical services you receive, you can apply for financial assistance. We will review your application to determine if you or your family member qualifies for governmental assistance such as Medicaid, community assistance, or financial assistance.

Financial assistance for medically necessary services is limited and is not intended to replace reasonable financial planning, health insurance coverage, or available public funding for which you may qualify.

Instructions for completing this application:
Please complete the attached Financial Assistance Application and provide the required documentation listed below. Please ***do not leave any items blank!*** Your application cannot be processed if the information provided is incomplete.

Your application will be evaluated according to Section 311 of the Texas Health and Safety Code as well as the guidelines set forth by section 501-R of the Affordable Care Act. We are required to determine your eligibility for assistance based upon federal poverty guidelines and all sources of income for you and your family. In some cases, we are required to consider your financial resources, assets, and non-exempt property in addition to income.

Accordingly, we require that you provide the following documentation regarding your application. Proof of income from every household member must be included before we can process the application. If you do not have a document, please indicate N/A next to the missing document. Any information received is subject to verification.

Please provide all that apply:

__ Most recent Income Tax Return for each working family member (*Previous year's return accepted through **April 15th**. Ex: 2015 Tax Return will be accepted through April 15th of 2017)*
__ Check Stubs; ***three*** *most recent pay periods for <u>each</u> working family member*
__ Letter from employer on company stationery confirming income amount stated on application
__ Letter from unemployment office
__ Letter from Social Security Office or copy of Social Security check
__ Documentation on any other forms of Income (*Child Support, Alimony, Retirement Income, Trust Funds, etc.)*

If you have questions or need assistance completing this form, please direct your calls to 512-268-9592.
Please submit your completed Financial Assistance Application, along with all requested documentation, in person or by mail to the address below:

PAM Rehabilitation Hospital of Round Rock
351 Seton Parkway
Round Rock, TX 78665
Attn: Admissions Office

Once all information is provided, your application will be processed and notification of the determination will be mailed to the guarantor address on file. Your Financial Assistance eligibility will be upheld for 30 days. More than 30 days past the initial application, you must reapply for any additional assistance needed. Similarly, if you are applying for financial assistance retroactively, your eligibility determination will apply to any outstanding balances.

FINANCIAL ASSISTANCE APPLICATION

RESPONSIBLE PARTY NAME: LAST	FIRST	MIDDLE
PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY		HOSPITAL ACCOUNT # (S):
SPOUSE		NUMBER OF DEPENDENTS
STREET ADDRESS		HOME PHONE ( )
CITY, STATE & ZIP		WORK PHONE ( )

OCCUPATION	EMPLOYER (IF SELF EMPLOYED, DESCRIPTION)
SOCIAL SECURITY #	ADDRESS
YEARS AT EMPLOYER	SALARY _____ ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY OTHER INCOME:_____ SOURCE_____

SPOUSE

OCCUPATION	EMPLOYER (IF SELF EMPLOYED, DESCRIPTION)
SOCIAL SECURITY #	ADDRESS

PHONE ( )	YEARS AT EMPLOYER	SALARY _____ ☐HOURLY ☐BIWEEKLY ☐MONTHLY
OTHER INCOME	SOURCE	

ASSETS		**LIABILITIES/** MONTHLY TOTALS	
CASH ON HAND	$_____	MORTGAGE/RENT PAYMENT	$_____
CHECKING ACCOUNT*	$_____	INSURANCE PREMIUMS:	
SAVINGS ACCOUNT*	$_____	☐AUTO, ☐MEDICAL, ☐HOME	$_____
CREDIT UNION ACCOUNT*	$_____	OTHER: _____	
REAL ESTATE EQUITY	$_____	UTILITIES: ☐ GAS, ☐ ELECT., ☐ WATER, ☐ PHONE	
MOTOR VEHICLES OWNED	$_____		$_____
MAKE/YEAR	VALUE_____	AUTO PAYMENTS	$_____
MAKE/YEAR	VALUE_____	FOOD	$_____
TRUST ACCOUNTS	$_____	OTHER LIABILITIES:	
OTHER SOURCES (STOCK, BONDS)	$_____	DESCRIPTION PAYMENT BALANCE	

*BANK BRANCH (S) & ACCOUNT NUMBERS:

I HEREBY DECLARE THE FOREGOING TO BE TRUE UNDER PENALTY OF PERJURY UNDER LAW.

Signature _____ Date _____