MEMORIAL HERMANN

# Patient Financial Assistance Summary

Memorial Hermann Health System offers *financial assistance* to eligible patients based on income and assets for partially or fully discounted emergent or medically-necessary care.

Patients seeking *financial assistance* must apply for the program.

***To see if you qualify for financial assistance*** **and** ***for free confidential help in applying, contact:***

**Patient Business Services**
**16906 Southwest Freeway**
**Sugar Land, TX 77479**
**Attention: Financial Assistance**
**Phone: 281-243-1073**
**Email: mjohnson3@uspi.com**

**http://memorialhermannfirstcolony.com**

## What Services are Covered?

The Financial Assistance Policy (FAP) covers emergency and medically-necessary services provided at a Memorial Hermann Hospital. The policy does *NOT COVER*: cosmetic procedures, services provided by physicians and other providers who treat you at a Memorial Hermann Hospital but are not employed by the Hospital, or providers who bill separate from the Hospital for their services.

## How to Apply

The FAP and Application may be obtained in-person, via mail, via telephone and from the Memorial Hermann website. Complete the application, include the requested documents and submit to the Hospital Admission/Registration Department *or* to the address listed on the back of this brochure.

## Income Limits

One of the qualifying factors is income based on the table below:

| 2025 POVERTY GUIDELINES | |
|---|---|
| Persons in household | Income per Year |
| 1 | $ 15,650 |
| 2 | $ 21,150 |
| 3 | $ 26,650 |
| 4 | $ 32,150 |
| 5 | $ 37,650 |
| 6 | $ 43,150 |
| 7 | $ 48,650 |
| 8 | $ 54,150 |
| For families/households with more than 8 people: add $5,500 for each additional person | |

## Who Qualifies for Financial Assistance?

The amount of financial assistance depends on your income, size of your family and assets. Patients with family income of 200% of the Federal Poverty Level or less may be eligible for a discount of 100%. Patients with family income of over 200% of the Federal Poverty Level may be eligible for a discount.

***A FREE copy of the Financial Assistance Policy and the Financial Assistance Application are available in English and Spanish by:***

- Calling 281-243-1073 or email mjohnson3@uspi.com
- Requesting an application by mail 16906 Southwest Freeway, Attn: Financial Assistance, Sugar Land, TX 77479
- Downloading an application from the Hospital Website at the above link.

The following forms of ***picture*** identification are acceptable for proof of identity:

- State-issued driver license or identification card
- Passport (US or foreign)
- Identification card issued by Foreign Consulate
- Student identification card
- U.S. immigration document
- Credit card (with photo)

## FINANCIAL INFORMATION FORM

Patient Name:

Patient Street Address: City, State, Zip Code:

Account Number(s): Date(s) of Service:

INSTRUCTIONS: questions must be answered. If a question does not pertain, write N/A on the line.
**Attach a photocopy of <u>one</u> proof of identity with a picture (example: state-issued driver license or Passport with picture, etc.) ***
**Attach a photocopy of the most recent Income Tax return *<u>AND</u>***
**Attach a photocopy of <u>one</u> of the following proofs of income:**

** If photo ID is not available, other documents showing identity may be used. Contact phone number above for assistance.*

- [ ] Last 2 paycheck stubs
- [ ] Unemployment benefit confirmation slip
- [ ] Social Security check or award letter
- [ ] Letter from employer stating employee name, occupation, hourly wage, number of hours worked

****** This is not considered a complete application without the supporting documentation. ******

STATUS: [ ] Permanent Texas Resident [ ] Legal Resident [ ] Immigrant Visa [ ] Non-Immigrant Visa

MARITAL STATUS (check one): [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Other

CHILDREN UNDER 18 YEARS OLD AND OTHER DEPENDENTS WITHIN THE HOUSEHOLD (Continue on another page, if needed)

| Full Name | Date of Birth | Relationship of Dependents (check one) | | | | |
|---|---|---|---|---|---|---|
| | | Child | Step-Child | Guardian | Adult/Senior | Not Related |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

EMPLOYMENT SUMMARY

| Patient | Spouse |
|---|---|
| Employer | Employer |
| Occupation | Occupation |
| Employment Status (check one)<br>[ ] Full-time [ ] Part-time [ ] Unemployed<br>[ ] Housewife [ ] Unable to return to work | Employment Status (check one)<br>[ ] Full-time [ ] Part-time [ ] Unemployed<br>[ ] Housewife [ ] Unable to return to work |

| HOUSEHOLD INCOME PER MONTH | | HOUSEHOLD EXPENSES PER MONTH | |
|---|---|---|---|
| Patient | $ /mo. | Housing: | ____ Own/Loan ____ Rent |
| Spouse | $ /mo. | House Payment | $ /mo. |
| Alimony | $ /mo. | Utilities (electric, water) | $ /mo. |
| Unemployment | $ /mo. | Car # 1 | $ /mo. |
| Child Support | $ /mo. | Car # 2 | $ /mo. |
| Survivors Benefit | $ /mo. | Gasoline | $ /mo. |
| Workers Comp | $ /mo. | Insurance | $ /mo. |
| Trust Fund | $ /mo. | TV/ Cable / Phone | $ /mo. |
| Other | $ /mo. | Food | $ /mo. |
| **TOTAL INCOME** | **$** /mo. | **TOTAL EXPENSES** | **$** /mo. |

BANK ACCOUNTS/OTHER ASSETS (must answer all 3 questions):

| | | | | |
|---|---|---|---|---|
| Checking Account? (circle one) | Yes | No | Current Balance | $ |
| Savings Account? (circle one) | Yes | No | Current Balance | $ |
| Additional Property? (circle one) | Yes | No | Current Value | $ |

If Yes, please describe: ________

## FINANCIAL INFORMATION FORM / FINANCIAL ASSITANCE APPLICATION

Patient Name:

* I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.

* The information I provided reflects HOUSEHOLD income and expenses.

* This information as well as a credit report and other publicly available information may be used by Memorial Hermann to establish a payment plan and/or to initiate an application for financial assistance and/or to determine eligibility for various programs, coverage or assistance.

* I give my consent to Memorial Hermann to obtain information from any source to verify the statements I have made.

* You will receive written communication from Memorial Hermann if the information provided is incomplete or insufficient to determine your eligibility for financial assistance or if you do not meet the eligibility qualifications. You will also be notified in writing if you are eligible for financial assistance.

* Patients who apply for financial assistance may be eligible for funds from local, state, or federal programs. Patients are expected to apply for such programs before a determination of eligibility for financial assistance. Memorial Hermann will provide assistance to individuals in applying for such programs. If a patient refuses to apply for, or follow through with an application for Medicaid or other coverage, the patients Financial Assistance Application will be denied.

* I affirm to the fact that I have applied for all possible insurance coverage, including Medicaid, Crime Victims, Health Exchange Insurance and any other local, state or federal coverage.

* I understand that if I do not qualify for financial assistance, I will be responsible for the cost of the care.

______________________________ ______________

Patient/Guarantor Signature Date

*After completing this application, mail it and ALL supporting documents to:*

**Patient Business Services**
**16906 Southwest Freeway**
**Sugar Land, TX 77479**
**Attention: Financial Assistance**

*Office Use Only*
***Financial Assistance Approved by Facility CEO / CFO***

Approved by:______________________________ ______________

Name / Signature Title Date