Wise Health System

Date: _____Guarantor Name: _____
Patient Name: _____Date of Service: _____
Hospital Visit #: _____Medical Record #: _____

Dear Patient:

Attached you will find the Wise Health System Financial Assistance Application. Completion of this application will enable us to present your account for consideration of financial assistance for your WHS hospital or WHC bill(s). **This is for your WHS and WHC services/charges only.**

Applications are completed in the order in which they are received and may take up to thirty (30) days to complete. **All required documents must be received within 30 days of the Application Date.** Applicants with a tax-supported hospital offering the same services available in their county of residence will be considered only after available resources are utilized.

If you do not have insurance, please call Michele Burch at 682-316-6532 to be screened for Governmental Insurance before submitting your application.

****PLEASE PROVIDE THE FOLLOWING DOCUMENTS****

***MOST RECENT INCOME TAX RETURN (COMPLETE INCOME TAX RETURN IS REQUIRED AND MUST ACCOMPANY ALL APPLICATIONS.)**
***PROOF OF INCOME: THREE (3) MOST RECENT PAYROLL CHECK STUBS WITH GROSS INCOME, SELF EMPLOYMENT INCOME, SOCIAL SECURITY BENEFITS, PENSIONS AND RETIREMENT BENEFITS, UNEMPLOYEMENT COMPENSATION, WORKERS COMPENSATION, VETERANS' PAYMENTS, ALIMONY, CHILD SUPPORT, INCOME FROM DIVIDENDS, INTEREST, RENTS, ROYALTIES, ESTATES AND TRUST.**
***IDENTIFICATION FOR EACH ADULT HOUSEHOLD MEMBER.**
***PROOF OF ADDRESS (UTILITY BILL, LEASE AGREEMENT, VERIFICATION OF ASSISTANCE LETTER, STATE OF FEDERAL CORRESPONDENCE, ETC.)**
***PROOF OF BEING DENIED OTHER FINANCIAL ASSISTANCE PROGRAMS.**
***CURRENT MONTHS CHECKING AND SAVINGS ACCOUNT STATEMENTS.**

****FAILURE TO PROVIDE THE REQUESTED DOCUMENTATION CAN RESULT IN A DENIAL FOR FINANCIAL ASSISTANCE CONSIDERATION****

Our Mission: Provide compassionate and innovative care to our community and patients with transparency and excellence.
Our Vision: Transformed and improved lives through better health and extraordinary outcomes.

If you have any questions or need any help, please feel free to call.
(940)626-1271 - Heather Justiss – 8:00-4:30pm M-F - hjustiss@wisehealthsystem.com
(940)626-1304 – Veronica Zuniga – 8:00-4:30pm M-F vzunigaper@wisehealthsystem.com

Mailing Address: 2000 S FM 51, Decatur, Texas 76234

Physical Address: 609 Medical Center Dr. Decatur, TX 76234 Phone #: 940-539-3644 Fax #: 940-626-1226

Wise Health System

APPLICATION FOR FINANCIAL ASSISTANCE – PAGE 1

Patient Name: Last _____ First _____ MI _____

Social Security #: _____ **DOB:** _____ **Hospital Visit #:** _____ **MRN #:** _____

Married _____ **Single** _____ **Divorced** _____ **Widowed** _____ **Separated** _____

Do you have minor children (under 18)?	_____Yes _____No
Do they live with you?	_____Yes _____No
Are they your birth/legally adopted children?	_____Yes _____No
Patient Employed?	_____Yes _____No
Spouse Employed?	_____Yes _____No
Do you have medical Insurance?	_____Yes _____No
Are you on Disability? How long? _____	_____Yes _____No
Are you a veteran?	_____Yes _____No

FAMILY MEMBERS – (Living in the home)

Spouse: _____ DOB: _____
Child: _____ DOB: _____
Child: _____ DOB: _____
Child: _____ DOB: _____
Child: _____ DOB: _____
Other: _____ DOB: _____

INCOME (Monthly Amount):	**Gross**	**Net**
Patient	$_____	$_____
Spouse	$_____	$_____
Dependents	$_____	$_____
Public Assistance	$_____	$_____
Food Stamps	$_____	$_____
Social Security	$_____	$_____
Unemployment	$_____	$_____
Workers Compensation	$_____	$_____
Child Support	$_____	$_____
Pensions	$_____	$_____
Income from: CD's Rent, Dividends Interest	$_____	$_____
TOTAL	$_____	$_____

Expenses	**Monthly Amount**
Mortgage/Rent	$_____
Utilities	$_____
Car Payments	$_____
Food / Groceries	$_____
Credit Cards	$_____
Other (Please Specify)	$_____
TOTAL	$_____

ASSETS

Checking Account	$_____
Savings Account	$_____
CD's, IRA's	$_____
Other Investments (Stocks, bonds, etc.)	$_____
Properties/Land other than primary residence	$_____

Wise Health System

APPLICATION FOR FINANCIAL ASSISTANCE – PAGE 2

Name of Employer: _____
Telephone #: _____
Employer Address: _____
Occupation: _____

Spouse's Employer:_____
Telephone #: _____
Employer Address: _____
Occupation: _____

Are you currently applying for Medicaid Benefits? _____Yes _____ No
Have you applied for assistance though County Indigent program? _____Yes _____ No
Do you have Health Insurance? _____Yes _____ No
If Yes: Insurance Name:_____Policy #:_____Group#:_____

VERIFICATION OF INCOME MUST BE AT LEAST FOR THE LAST (3) PAY PERIODS. YOU MAY USE A COPY OF YOUR SOCIAL SECURITY CHECK/AWARD LETTER, BANK STATEMENT VERIFING DIRECT DEPOSIT. YOU WILL NEED TO PROVIDE COPIES OF ALL SAVINGS AND CHECKING ACCOUNTS. YOU WILL BE REQUIRED TO SHOW PROOF THAT YOU HAVE APPLIED FOR AND BEEN DENIED ASSISTANCE FOR ANY OTHER GOVERNMENT ASSISTANCE PROGRAMS.

I UNDERSTAND WISE HEALTH SYSTEM WILL VERIFY THE FINANCIAL INFORMATION IN THIS FINANCIAL ASSISTANCE APPLICATION IN CONNECTION WITH WHS EVALUATION OF THIS APPLICATION, AND WITH MY SIGNATURE I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND ARE MADE IN GOOD FAITH; I WILL APPLY FOR ANY ASSISTANCE SUCH AS MEDICAID, CIHP, CRIME VICTIMS COMPENSATION, SSI OR INSURANCE THAT MAY BE AVAILABLE, FOR PAYMENT OF MY HOSPITAL CHARGES. I AM AWARE THAT FALSIFICATION OR MISREPRESENTATION OF INFORMATION ON THIS APPLICATION MAY RESULT IN DENIAL OF FINANCIAL ASSISTANCE.

**** DISCLAIMER: APPROVAL OF WHS PATIENT ASSISTANCE PROGRAM DOES NOT RELEASE YOU OF ANY OBLIGATION WITH YOUR OTHER HEALTH CARE PROVIDERS. ****

_____ _____
SIGNATURE OF PERSON MAKING REQUEST, IF PATIENT **DATE**

_____ _____
SIGNATURE OF PERSON MAKING REQUEST, IF NOT PATIENT **DATE**

_____ _____
PATIENT'S ADDRESS CITY STATE ZIP COUNTY **TELEPHONE NUMBER**

Mailing Address: 2000 S FM 51, Decatur, Texas 76234