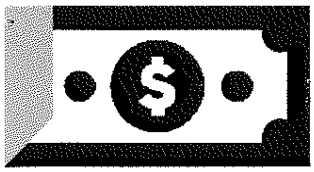

Need financial assistance?

As part of its mission and commitment to the community, Baylor Scott & White Health affiliated hospitals provide financial assistance to patients who qualify for assistance pursuant to Baylor Scott & White's Financial Assistance Policy (FAP).

Eligibility requirements:

All patients can qualify for financial assistance for emergency care or when a Baylor Scott & White facility accepts a transfer from another facility. For non-emergency, medically necessary care, financial assistance is available to patients living in the Baylor Scott & White service area described below as long as the facility is the closest provider to their current residence (including non-Baylor Scott & White affiliated facilities) providing their care.

Established discount guidelines are utilized to determine what amount, if any, will qualify for financial assistance.

- Generally, qualifying patients with family income at or below 200% of the Federal Poverty Guidelines (FPG) will receive a 100% discount.
- Qualifying patients with family incomes ranging from greater than 200% up to 500% of FPG, with Baylor Scott & White medical bills equal to or greater than 5% of their yearly income, are eligible to pay a discounted amount that is the lesser of the patient's account balance or 10% of gross charges.
- Patients must exhaust all other payment options, third-party funding, and medical assistance programs. If a patient does not cooperate and pursue all options, financial assistance may be denied or revoked if already approved.

How to apply for financial assistance:

Free copies of the FAP and the FAP application, and assistance with answering questions and completing the application, can be obtained through any of these sources:

- In person: Hospital Admission Office
- Over the phone: **903.870.0999**
- Online: **BSWHealth.com/FinancialAssistance**
- By mail: Baylor Scott & White Surgical Hospital – Sherman
  Attn: Business Office
  3601 N. Calais Drive
  Sherman, TX 75090

Additionally, Baylor Scott & White can initiate an assistance application on behalf of the patient. There is no assurance that the patient will qualify for financial assistance. English, Spanish and certain other language versions of the FAP application are available upon request.

Charges for emergency or medically necessary care:

No patient who qualifies for financial assistance will be charged more for emergency or other medically necessary care than amounts generally billed to patients having insurance.

Baylor Scott & White service area

Patients living in the counties listed below are eligible for financial assistance for non-emergency, medically necessary care.

Anderson	Burnet	Denton	Hays	Kaufman	Navarro	Smith	Waller
Bell	Collin	Ellis	Henderson	Llano	Parker	Tarrant	Washington
Blanco	Cooke	Grayson	Hood	McLennan	Rockwall	Travis	Williamson
Brazos	Coryell	Gregg	Hunt	Milam	San Saba	Van Zandt	Wood
Burleson	Dallas	Grimes	Johnson				

Baylor Scott & White HEALTH

BaylorScott&White HEALTH

Baylor Scott & White Health
Financial Assistance Application

Patient Account Number

Patient Name (Last, First, MI) Social Security Number

Patient Address City State Zip Code

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Birth Date (Month/Date/Year) Telephone Number

Spouse's Name

Employed ☐ Yes ☐ No

Patient's Employer

Telephone #

Employed ☐ Yes ☐ No

Spouse's Employer

Telephone #

Other Baylor Scott & White Health accounts for your household with an unpaid balance (Please list patient's NAME, DOB and FACILITY NAME)

If unemployed, please include the previous employer's name and telephone number*

A. ***Income:*** Please provide the income for each of the following persons in your household.

Patient ☐ Full Time ☐ Part Time - Hours/Week = _____
$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year

$ _____ **Additional Income**

Spouse ☐ Full Time ☐ Part Time - Hours/Week = _____
$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year

$ _____ **Additional Income**

Total Household Income $ _____

Please complete only if patient is a minor (if not leave blank)

Patient's Father ☐ Full Time ☐ Part Time - Hours/Week = _____
$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year

$ _____ **Additional Income**

Patient's Mother ☐ Full Time ☐ Part Time - Hours/Week = _____
$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year

$ _____ **Additional Income**

Total Household Income $ _____

B. ***Income Verification:*** Please provide verification ***(send only copies, no original documentation)*** for all sources of household income (acceptable documentation listed below).
Check attached documents:

☐ Paycheck Remittance ☐ Employer Verification ☐ Credit Inquiry (completed by BSWH)
☐ IRS Form W-2 ☐ Tax Return ☐ Governmental Assistance (food stamps, CDIC, Medicaid, TANF)
☐ Bank Statements ☐ Other (describe below) ☐ Social Security, Workers Compensation or Unemployment Compensation Determination Letters

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

_____

C. ***Family Members:*** **Please provide the total number of people in the patient's household.**
(This number should only include the patient, patient's spouse, and the patient's dependents)

D. ***Assets and Other Resources:***

Do you have any assets or other resources available to you? *(Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)*	☐ Yes	☐ No	If Yes, current amount available: $_____
Do you have medical insurance?	☐ Yes	☐ No	If Yes, please list provider name: _____
Do you have a Health Savings Account or Flexible Spending Account?	☐ Yes	☐ No	If Yes, current amount available: $_____

I understand Baylor Scott & White Health ("BSWH") may verify the financial information contained in this Financial Assistance Application ("Application") in connection with BSWH's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize BSWH to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance.

I further understand that some physicians and providers may not be employees of BSWH. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

Signature of Patient or Responsible Party **Printed Name** **Date**

For Hospital Use Only

☐ Application information obtained by BSWH Employee in person or over the phone, no patient signature required.

Electronic Signature of BSWH Employee or BSWH Representative Date

Notes Regarding Income Verification/Number in the Household:

☐ Patient is part of community care program Program Name _____