THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

# Patient Financial Assistance Application Instructions

Attached you will find the MD Anderson Financial Assistance Application. Completion of this application will allow us to review your eligibility for receiving assistance from this program.

To determine if you qualify, we require the following supporting documentation:

- Verification of Texas Residency (past 6 months)
- Verification of Citizenship, lawful permanent residency (5 years), or certain immigrant status
- Verification of Income and Assets

It is important that you complete this application and return it with all required documentation within 15 days. If you have difficulty completing this application or you have additional questions, please call the Financial Clearance Center, Monday through Friday, from 8 a.m. to 6 p.m. at 713-792-4322 or 844-294-4322.

Application Instructions:

1. Complete each item on the application.
2. Provide supporting documentation from the document list (please refer to the last page of this packet).
3. Submit application and supporting documentation.
   - Email: Submit fillable application and supporting documentation to: PFA@MDAnderson.org
   - Fax: 832-750-0610
   - Mail to:

     The University of Texas MD Anderson Cancer Center
     Financial Clearance Center / Patient Financial Assistance
     P.O. Box 301407 / Unit 1605
     Houston, Texas 77230-1407

Your cooperation is appreciated. Submission of a completed application and required documentation does not guarantee approval for financial assistance, and you remain responsible for your account balance.

Sincerely,

Patient Financial Assistance Office
UT MD Anderson Cancer Center

# Patient Financial Assistance Application

This application is used to evaluate your eligibility for the University of Texas MD Anderson Cancer Center's Patient Financial Assistance Program. To ensure prompt review of your application, please complete all sections. **Do not leave blanks, if not applicable enter "NA."** You must submit documents to confirm your identity, Texas residency for the past six continuous months, your citizenship status, all income and assets. We may request additional documents if necessary to complete your application

**Medical Record/Referral Number:**

**Application Date:**

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## Patient Information

**Required Documents**

A copy of your valid, current Texas Driver's License or other valid, current government photo ID.

**Patient's Name:**

**Telephone Number:**

**Date of Birth:**

**Sex:**

**Texas Driver's License Number:**

**Marital Status:**

☐ Single ☐ Married ☐ Widowed (Year ) ☐ Separated (Year ) ☐ Divorced (Year )

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**If Minor, Parent/Guardian Name:**

**Telephone Number:**

**Date of Birth:**

**Sex:**

**Texas Driver's License Number:**

**Marital Status:**

☐ Single ☐ Married ☐ Widowed (Year ) ☐ Separated (Year ) ☐ Divorced (Year )

# Patient Financial Assistance Application

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**Please check the applicable document and attach a copy.**

## What is the patient's citizenship status?

**If a U.S. citizen:**

- ☐ Valid U.S. Birth Certificate, valid Certificate of Birth Abroad, or valid Report of Birth Abroad
- ☐ Valid current U.S. Passport or Passport Card
- ☐ U.S. Citizen Identification Card
- ☐ Certificate of Naturalization or Individual Fee Register Receipt for application for New Naturalization or Citizenship Paper

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**If a Lawful Permanent Resident:**

- ☐ I hereby attest that I am a Lawful Permanent Resident of the U.S.
- ☐ Valid current Resident Alien Card (Effective Date: ☐)

*(A conditional Lawful Permanent Resident Card is not acceptable.)*

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**If a member of any of the following immigrant categories:**
Asylee, refugee, victim of severe trafficking, alien whose deportation is withheld, Active Duty or Veteran U.S. Military/dependent, alien battered spouse of U.S. Military or Veteran.

- ☐ Court Order
- ☐ USCIS petition
- ☐ I-94 with appropriate stamp
- ☐ Military or Veteran Documentation
- ☐ USCIS grant letter
- ☐ Other documentation:

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**Attention**

**If you are unable to prove that you are an American citizen, a Lawful Permanent Resident for at least five years, or a member of one of the listed immigrant categories, contact the Financial Clearance Center at 713-792-4322.**

# Patient Financial Assistance Application

## 3 Where is the patient's primary residence?

**Current Address:** *(Physical Address, not P.O. Box)*

| **City:** | **State:** | **Zip Code:** |
|---|---|---|
| | | |

| **Country:** | **From Date:** | **To Date:** |
|---|---|---|
| | | |

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**Previous Address:**

| **City:** | **State:** | **Zip Code:** |
|---|---|---|
| | | |

| **Country:** | **From Date:** | **To Date:** |
|---|---|---|
| | | |

*(If less than six months, attach separate sheet showing previous addresses for the past six months)*

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**Can you claim residency in another state?** ☐ **Yes** ☐ **No**

If yes, where?

# Patient Financial Assistance Application

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## Where is the patient's primary residence?

*(Continued)*

**Please check the applicable document and attach a copy.**

**A. Proof that your primary residence has been in Texas for at least the past six continuous months – submit any ONE of the following:**

- ☐ Your deed or recent property tax statement or receipt
- ☐ A lease with the applicant name
- ☐ Other

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**B. Proof you have resided in Texas for the past six months – submit any TWO of the following documents:**

- ☐ Valid current Texas Drivers License or ID Card
- ☐ Vehicle registration
- ☐ Utility bills in your name for the past six months
- ☐ Valid Current Texas Voter Registration
- ☐ Bank statements/cancelled checks for the past six months
- ☐ Notarized letter from Texas employer on company letterhead showing dates and location of employment
- ☐ Proof of Texas public benefits (food stamps, etc.) for the past six months
- ☐ Proof of Texas public or private school enrollment (if the patient is a child) for the past six months
- ☐ Approved registration for Texas city or county health care benefits for the past six months
- ☐ Proof of in-state tuition benefits for the past six months

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**Attention**

**If you are unable to prove that you have resided in Texas continuously for the past six months, contact the Financial Clearance Center at 713-792-4322.**

# Patient Financial Assistance Application

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**Please circle all that apply.**

**Failure to disclose coverage or dropping coverage may result in the denial of your application.**

## Does the patient have insurance or other coverage?

**Texas Medicaid?** ☐ **Yes** ☐ **No**

Texas Medicaid patients do not have to complete this application.

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**Traditional Medicare?** ☐ **Yes** ☐ **No**

Medicare ID#:

Check current enrollments: ☐ A ☐ B ☐ D

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**Medicare Advantage Plan?** ☐ **Yes** ☐ **No**

If yes, Insurance Name:

Policy Number:

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**HMO, PPO, or Indemnity Insurance?** ☐ **Yes** ☐ **No**

If yes, Insurance Name:

Policy Number:

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**COBRA or COBRA-eligible?** ☐ **Yes** ☐ **No**

If yes, COBRA enrollment is required.

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**Active Duty Military or Dependent?** ☐ **Yes** ☐ **No**

If yes, Insurance Name:

Policy Number:

# Patient Financial Assistance Application

## 4 Does the patient have insurance or other coverage?

*(Continued)*

**Veterans Administration Benefits?** ☐ **Yes** ☐ **No**

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**Workers' Compensation?** ☐ **Yes** ☐ **No**

If yes, Adjuster Name:

Phone Number:

## 5 Eligibility Assistance Program

**Attention**

You may be eligible for additional assistance such as Social Security Disability, Medicaid, or county assistance programs. Please contact 713-563-0280 or 1-855-236-5678 for a free screening and to learn if you qualify. You must be screened for these programs before being considered for the patient financial assistance program.

**This screening is required for all applicants.**

## 6 Employer

### Patient or Legal Guardian Employer

Employer Name:

Address:

City:

State:

Zip Code:

Country:

Telephone:

Position Held:

# Patient Financial Assistance Application

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## Employer

*(Continued)*

### Spouse Employer

Employer Name:

Address:

City:

State:

Zip Code:

Country:

Telephone:

Position Held:

# Patient Financial Assistance Application

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**Do not list the patient (attach additional pages if necessary).**

## Family size

Please list everyone who the patient is legally responsible for including spouse and dependents.

**Name:**

**Relationship to Patient:** **Age:** **Student?** **Family Income Contributor?**

☐ Yes ☐ No ☐ Yes ☐ No

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**Name:**

**Relationship to Patient:** **Age:** **Student?** **Family Income Contributor?**

☐ Yes ☐ No ☐ Yes ☐ No

---

**Name:**

**Relationship to Patient:** **Age:** **Student?** **Family Income Contributor?**

☐ Yes ☐ No ☐ Yes ☐ No

---

**Name:**

**Relationship to Patient:** **Age:** **Student?** **Family Income Contributor?**

☐ Yes ☐ No ☐ Yes ☐ No

---

**Name:**

**Relationship to Patient:** **Age:** **Student?** **Family Income Contributor?**

☐ Yes ☐ No ☐ Yes ☐ No

# Patient Financial Assistance Application

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## Assets

**Please complete for the patient and everyone listed in Family Size section. Enter a zero for anything that does not apply.**

**Attach additional sheets if necessary and include in total.**

### Banking Information (Checking/Savings/CD)

Account Number:

Institution Name:

Date: Current Balance:

---

Account Number:

Institution Name:

Date: Current Balance:

---

Account Number:

Institution Name:

Date: Current Balance:

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**A. Checking/Savings/CD Total:**

# Patient Financial Assistance Application

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## Assets

*(Continued)*

### Stocks/Bonds/Other Securities, 401K, and/or Trusts

Account Number:

Institution Name:

Date: Current Balance:

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Account Number:

Institution Name:

Date: Current Balance:

---

Account Number:

Institution Name:

Date: Current Balance:

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**B. Securities Total:**

# Patient Financial Assistance Application

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## Assets

*(Continued)*

### Equity Value of Real Estate/Property other than Primary Residence

County Appraisal District market value minus the mortgage:

Institution Name:

County Appraisal District market value minus the mortgage:

Institution Name:

County Appraisal District market value minus the mortgage:

Institution Name:

**C. Equity Total:**

**Please check all that apply & submit copies for the patient and everyone listed in Family Size section.**

- ☐ Bank statements – 3 most current months
- ☐ Certificate of Deposit statements – 3 most current months
- ☐ County Tax Appraisal for property other than Primary Residence
- ☐ Securities statements (stocks/bonds/other) – last quarter
- ☐ Mortgage Statement for property other than Primary Residence
- ☐ Most Recent Trust Bank Statement

# Patient Financial Assistance Application

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## Family income

**Please complete for the patient and everyone listed in Family Size section.**

**Does anyone claim the patient as a dependent or tax credit?** ☐ **Yes** ☐ **No**

If yes, who?

**Did the patient/spouse/guardian file a U.S. FEDERAL INCOME TAX RETURN last year?**

If no, please submit a IRS non-filing statement.

To obtain a statement, please contact the IRS at 1-800-829-1040 or visit www.IRS.gov.

**Adjusted Gross Income:**

**Total Monthly Living Expenses:**

**Is monthly Adjusted Gross Income less than total monthly expenses?**

☐ **Yes** ☐ **No**

If yes, state how expenses are being met:

# Patient Financial Assistance Application

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## Family income

*(Continued)*

**Check all the following that apply to anyone listed in the family section of the application:**

- ☐ Farms
- ☐ Rental Income
- ☐ Business

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**Please check all that apply & attach copies.**

- ☐ U.S. Individual Income Tax Return - Form 1040, 1040 EZ, etc., with W-2 and all Schedules and attachments for the most recent year.
- ☐ IRS Statement of Non-Filing if U.S. Individual Tax Return was not completed
- ☐ Paycheck stubs or payroll records for the past 3 months if you filed an income tax return or last 12 months without an income tax return
- ☐ Social Security Earnings Statement or most recent Social Security Award Letter
- ☐ Disability earnings statement (most recent)
- ☐ Unemployment Compensation
- ☐ Statements of interest income and capital gains distributions (most recent)
- ☐ Income statements from IRAs, pensions, annuities or any source for the past 12 months if not reported on Income Tax Return
- ☐ Documentation of all other income for the past 12 months that is not listed above (housing or vehicle allowance/stipend, insurance or estate distributions, winnings from gambling or lotteries, court judgments and earnings from any other source)

# Patient Financial Assistance Application

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## Certification

**The patient or parent/guardian must sign this Certification.**

I understand that this assessment may not be processed until all required information is submitted. I understand that additional information may be required to process my application.

I certify that the information provided in this assessment is complete and accurate to the best of my knowledge. I agree to notify MD Anderson Cancer Center of any change in my insurance eligibility or financial status. I authorize MD Anderson Cancer Center to verify all submitted information.

I understand that if any information that I have submitted is found to be inaccurate, false, or misleading, any assistance that may have been approved will be rescinded, I will be responsible for all charges incurred as of my first date of service, I will be required to pay in advance for any future services, and I may risk discontinuance of services and/or legal action.

**Applicant Signature:**

**Print Name:**

**Date:**

**Relationship to Patient:**

☐ This application can be delivered electronically. The applicant consents to using an electronic signature to sign this application and acknowledges all the above information still applies.

Patient Name: _____

MRN: _____

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# Patient Financial Assistance Application Document List

**Identification (one required)**

- ☐ Valid Texas Driver's License with photo
- ☐ Valid Texas Identification with photo
- ☐ Valid current U.S. Passport or Passport Card with photo
- ☐ Valid current Permanent Resident Card (Green Card) with photo
- ☐ Other valid current government issued photo ID

**Proof of Citizenship (one required)**

- ☐ Birth Certificate from U.S. or outlying possessions
- ☐ Valid U.S. Passport or U.S. Passport Card
- ☐ Certificate of Naturalization or Certificate of Citizenship
- ☐ U.S. Certificate from Birth Abroad
- ☐ USCIS Form I-551 (Green Card) (Must be permanent resident 5 years or longer)

**Residence Proof (one required)**

- ☐ Deed or Property Tax Assessment in Applicant's Name
- ☐ Lease in Applicant's Name
- ☐ Non-Leasing Resident in Rental Unit (Notarized Letter)
- ☐ Non-Leasing Resident in Homestead (Notarized Letter)

**Residence Indicator (two required)**

- ☐ Valid Texas Driver's License or identification card with photo
- ☐ Texas Voter Registration Card
- ☐ Bank Statements with TX address - 6 most recent months (patient/spouse)
- ☐ Unemployment compensation, Food Stamps, with TX address (patient/spouse)
- ☐ Utility Bills in applicants name with TX address (Electric, Natural Gas, Water, Cable)
- ☐ Letter/Card for a Texas County Indigent Health Care Benefits (past 6 months with TX address)
- ☐ Notarized letter from Texas employer (on company letterhead) showing dates and location of employment
- ☐ Proof of Texas public or private school or university enrollment for past six months

**Assets (all that apply)**

- ☐ Bank Statements; ALL Accounts (3 most current months) (patient/spouse)
- ☐ If NO BANK ACCOUNT (complete Verification of No Bank Account Form)
- ☐ Certificate of Deposit Statements (3 most recent months) (patient/spouse)
- ☐ County Tax Appraisal for property other than Primary Residence
- ☐ Securities Statements from last quarter (401K, Money Market, Stocks, Bonds, Etc) (patient/spouse)
- ☐ Mortgage Statement for property other than Primary Residence
- ☐ Most recent trust bank statement

**Income (all that apply)**

- ☐ Most recent U.S. Income Tax Return (paper or e-filed) (patient/spouse)
- ☐ IRS Verification of Non-Filing Statement (Form 4506T) (patient/spouse)
- ☐ Social Security (SSI or SSDI) Earning Statement or Social Security Award Letter (most recent) (patient/spouse)
- ☐ Payroll Complete Check Stubs (3 most recent months) (patient/spouse)
- ☐ Unemployment Compensation (patient/spouse)
- ☐ Texas Workforce Wage History Report for (patient/spouse)
- ☐ Family Support Letter

**Other (all that apply)**

- ☐ Proof/Verification of Current Insurance
- ☐ County Indigent Health Care Eligibility Determination Letter/ Card (most current)
- ☐ Eligibility Assistance Program Screening (required, call 713-563-0280)
- ☐ Divorce Decree/Death Certificate
- ☐ Proof of Health Insurance Marketplace Eligibility Determination