

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 5 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.** 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:

*Please Type or
Print Clearly in Ink.*

1

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____)

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____)

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WHAT IS THE PATIENT'S CITIZENSHIP STATUS?

Please check the applicable document and attach a copy.

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

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.)

If a member of any of the following immigrant categories:

Asylee, refugee, Cuban/Haitian entrant, Amerasian Lawful Permanent Resident, 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: _____



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.

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WHERE IS THE PATIENT'S PRIMARY RESIDENCE?

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

Address:

City:

State:

Zip Code:

County:

From Date:

To Date:

Previous Address:

City:

State:

Zip Code:

County:

From Date:

To Date:

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

Can you claim residency in another state? Yes / No

If yes, where?

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WHERE IS THE PATIENT'S PRIMARY RESIDENCE?

Required Documents

Please check the applicable documents and attach copies.

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
Military ID
Other

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
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



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.

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DOES THE PATIENT HAVE INSURANCE OR OTHER COVERAGE?



Please circle all that apply.

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

Texas Medicaid? Yes / No
Texas Medicaid patients do not have to complete this application.

Traditional Medicare? Yes / No
Medicare ID#: _____ Check current enrollments – A B D

Medicare Advantage Plan? Yes / No
If yes, Insurance Name & Policy Number:

HMO, PPO, or Indemnity Insurance? Yes / No
If yes, Insurance Name & Policy Number:

COBRA or COBRA-eligible? Yes / No
If yes, COBRA enrollment is required.

Active Duty Military or Dependent? Yes / No
If yes, Insurance Name & Policy Number:

Veterans Administration Benefits? Yes / No

Cancer Policy? Yes / No
If yes, Insurance Name, Policy Number & Phone Number:

Workers' Compensation Yes / No
If yes, Adjuster Name & Phone Number:

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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.

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EMPLOYER

Patient or Legal Guardian Employer:

Employer Name:

Spouse Employer Name:

Address:

Address:

Telephone:

Telephone:

Position Held:

Position Held:

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FAMILY SIZE

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

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

Name:

Relationship to Patient:

Family Income Contributor?

Age:

Student?

Yes / No

Yes / No

Yes / No

Yes / No

Yes / No

Yes / No

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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.

Banking Information:

Account No:	Institution Name:	Date:	Current Balance:
Checking			\$
Savings			\$
CD			\$

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

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

Account No:	Institution Name:	Date:	Current Balance:
			\$
			\$

***B. Securities Total:** \$

Equity Value of Real Estate/Property other than Primary Residence (County Appraisal District market value minus the mortgage):

Current Balance:
\$
\$

C. Equity Total: \$

**Attach additional sheets if necessary and include in 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

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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? Yes / No

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

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

Farms

Rental Income

Business

Required Documents

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*)

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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.

THE UNIVERSITY OF TEXAS
**MD Anderson
Cancer Center**

Making Cancer History®

Patient Name: _____

MRN: _____

Patient Financial Assistance Application Document List**IDENTIFICATION: (ONE REQUIRED)**

1. ___ Valid Texas Driver's License w/photo
2. ___ Valid Texas Identification w/photo
3. ___ Valid current U.S Passport or Passport Card w/photo
4. ___ Valid current Permanent Resident Card (Green Card) w/ photo
5. ___ Other valid current government issued photo ID

PROOF OF CITIZENSHIP: (ONE REQUIRED)

1. ___ Birth Certificate from U.S or outlying possessions
2. ___ Valid U.S. Passport or U.S Passport Card
3. ___ Certificate of Naturalization or Certificate of Citizenship
4. ___ U.S. Certificate from Birth Abroad
5. ___ USCIS Form I-551 (GREEN CARD)(Must be permanent resident 5 years or longer)

RESIDENCE PROOF: (ONE REQUIRED)

1. ___ Deed or Property Tax Assessment in Applicant's Name
2. ___ Lease in Applicant's Name
3. ___ Military ID w/Texas Address
4. ___ Non-Leasing Resident in Rental Unit (Notarized Letter)
5. ___ Non-Leasing Resident in Homestead (Notarized Letter)

RESIDENCE INDICATOR: (TWO REQUIRED)

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

ASSETS: (ALL THAT APPLY)

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

INCOME: (ALL THAT APPLY)

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

OTHER: (ALL THAT APPLY)

1. ___ Proof / Verification of Current Insurance
2. ___ County Indigent HealthCare Eligibility Determination Letter/ Card (most current)
3. ___ MedData Eligibility Assistance Program (required call 713-563-0280)
4. ___ Divorce Decree / Death Certificate
5. ___ Proof of Health Insurance Marketplace Eligibility Determination