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 for covered services under 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 800-527-2318.

Application Instructions:

1. Complete each item on application
2. Provide supporting documentation on the document check list
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

THE UNIVERSITY OF TEXAS
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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.

Please Type or Print Clearly in Ink.

Medical Record/Referral Number:

Application Date:

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*_____)

Patient Financial Assistance Application

2 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.

Patient Financial Assistance Application

3 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?**

Patient Financial Assistance Application

Continued...

3 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.

Patient Financial Assistance Application

4 DOES THE PATIENT HAVE INSURANCE OR OTHER COVERAGE?

STOP

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:

Patient Financial Assistance Application

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:	*Spouse Employer Name:*
Address:	*Address:*
Telephone:	*Telephone:*
Position Held:	*Position Held:*

7 FAMILY SIZE

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

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

Name:	Relationship to Patient:	Family Income Contributor?	Age:	Student?
		Yes / No		Yes / No
		Yes / No		Yes / No
		Yes / No		Yes / No

Patient Financial Assistance Application

8 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:

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

***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:

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

9 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

Continued...

9 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)*

Patient Financial Assistance Application

10 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.

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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