

Financial Assistance Application

Thank you for choosing Warm Springs Rehabilitation Hospital of Kyle. It is the policy of Warm Springs Rehabilitation Hospital of Kyle to offer financial assistance to patients who either do not have health insurance or are underinsured and may be not be able to pay in full for their health care based on their income, assets and needs.

If you are unable to pay for the medical services you receive, you can apply for financial assistance. We will review your application to determine if you or your family member qualifies for governmental assistance such as Medicaid, community assistance, or financial assistance.

Financial assistance for medically necessary services is limited and is not intended to replace reasonable financial planning, health insurance coverage, or available public funding for which you may qualify.

Instructions for completing this application:

Please complete the attached Financial Assistance Application and provide the required documentation listed below. Please **do not leave any items blank!** Your application cannot be processed if the information provided is incomplete.

Your application will be evaluated according to Section 311 of the Texas Health and Safety Code as well as the guidelines set forth by section 501-R of the Affordable Care Act. We are required to determine your eligibility for assistance based upon federal poverty guidelines and all sources of income for you and your family. In some cases, we are required to consider your financial resources, assets, and non-exempt property in addition to income.

Accordingly, we require that you provide the following documentation regarding your application. Proof of income from every household member must be included before we can process the application. If you do not have a document, please indicate N/A next to the missing document. Any information received is subject to verification.

Please provide all that apply:

- Most recent Income Tax Return for each working family member (*Previous year's return accepted through April 15th. Ex: 2015 Tax Return will be accepted through April 15th of 2017*)
- Check Stubs; **three** most recent pay periods for each working family member
- Letter from employer on company stationery confirming income amount stated on application
- Letter from unemployment office
- Letter from Social Security Office or copy of Social Security check
- Documentation on any other forms of Income (*Child Support, Alimony, Retirement Income, Trust Funds, etc.*)

If you have questions or need assistance completing this form, please direct your calls to 512-268-9592.

Please submit your completed Financial Assistance Application, along with all requested documentation, in person or by mail to the address below:

Warm Springs Rehabilitation Hospital of Kyle
5980 Kyle Parkway
Kyle, TX 78640
Attn: Admissions Office

Once all information is provided, your application will be processed and notification of the determination will be mailed to the guarantor address on file. Your Financial Assistance eligibility will be upheld for 30 days. More than 30 days past the initial application, you must reapply for any additional assistance needed. Similarly, if you are applying for financial assistance retroactively, your eligibility determination will apply to any outstanding balances.



A Seton Healthcare Family partner with Post Acute Medical

FINANCIAL ASSISTANCE APPLICATION

RESPONSIBLE PARTY NAME:		LAST	FIRST	MIDDLE
PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY				HOSPITAL ACCOUNT # (S):
SPOUSE				NUMBER OF DEPENDENTS
STREET ADDRESS				HOME PHONE ()
CITY, STATE & ZIP				WORK PHONE ()
OCCUPATION		EMPLOYER (IF SELF EMPLOYED, DESCRIPTION)		
SOCIAL SECURITY #		ADDRESS		
YEARS AT EMPLOYER	SALARY _____		<input type="checkbox"/> HOURLY <input type="checkbox"/> BIWEEKLY <input type="checkbox"/> MONTHLY	
	OTHER INCOME: _____		SOURCE _____	

SPOUSE

OCCUPATION		EMPLOYER (IF SELF EMPLOYED, DESCRIPTION)		
SOCIAL SECURITY #		ADDRESS		
PHONE ()	YEARS AT EMPLOYER	SALARY _____		
		<input type="checkbox"/> HOURLY <input type="checkbox"/> BIWEEKLY <input type="checkbox"/> MONTHLY		
OTHER INCOME	SOURCE _____			

ASSETS

LIABILITIES/ MONTHLY TOTALS

<p>CASH ON HAND \$ _____</p> <p>CHECKING ACCOUNT* \$ _____</p> <p>SAVINGS ACCOUNT* \$ _____</p> <p>CREDIT UNION ACCOUNT* \$ _____</p> <p>REAL ESTATE EQUITY \$ _____</p> <p>MOTOR VEHICLES OWNED \$ _____</p> <p style="padding-left: 20px;">MAKE/YEAR VALUE _____</p> <p style="padding-left: 20px;">MAKE/YEAR VALUE _____</p> <p>TRUST ACCOUNTS \$ _____</p> <p>OTHER SOURCES \$ _____</p> <p style="padding-left: 20px;">(STOCK, BONDS)</p>	<p>MORTGAGE/RENT PAYMENT \$ _____</p> <p>INSURANCE PREMIUMS:</p> <p><input type="checkbox"/> AUTO, <input type="checkbox"/> MEDICAL, <input type="checkbox"/> HOME \$ _____</p> <p style="padding-left: 40px;">OTHER: _____</p> <p>UTILITIES: <input type="checkbox"/> GAS, <input type="checkbox"/> ELECT., <input type="checkbox"/> WATER, <input type="checkbox"/> PHONE</p> <p style="text-align: right;">\$ _____</p> <p>AUTO PAYMENTS \$ _____</p> <p>FOOD \$ _____</p> <p>OTHER LIABILITIES:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">DESCRIPTION</th> <th style="text-align: left;">PAYMENT</th> <th style="text-align: left;">BALANCE</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	DESCRIPTION	PAYMENT	BALANCE						
DESCRIPTION	PAYMENT	BALANCE								

*BANK BRANCH (S) & ACCOUNT NUMBERS:

I HEREBY DECLARE THE FOREGOING TO BE TRUE UNDER PENALTY OF PERJURY UNDER LAW.

Signature _____

Date _____