PAM HEALTH
REHABILITATION HOSPITAL
OF KYLE
A SETON FAMILY OF HOSPITALS PARTNER

Letter of Support

Patient medical record number/account number ____

Supporter's name ____

Relationship to patient/applicant ____

Supporter's address ____

To Warm Springs Rehabilitation Hospital of Kyle:

This letter is to advise that (patient's name) ______________________ receives little to no income and I am assisting with his/her living expenses. He/She has little to no obligation to me. By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of Supporter: ____________________________________

Date: ______________________________________

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Dear Patient/Applicant,

PAM Health Rehabilitation Hospital of Kyle is driven by compassion and dedicated to providing personalized care for all—especially those most in need. It is our mission and privilege to offer financial assistance to our patients. Financial assistance is available only for emergency and other medically necessary care. Thank you for trusting us to care for you and your family for all of your healthcare needs.

We are sending this letter and the attached financial assistance application because we received your request. If you did not request this, please disregard. Please complete both sides, including your signature and date before returning it. If you completed an application within the past six months and were approved for financial assistance, please notify us. You may not need to complete a new application. We will not consider a prior application that is greater than six months old.

Along with the application, you will need to provide verification of your household's income and verification of all assets owned by any household member.

Examples of proof of income and assets include:

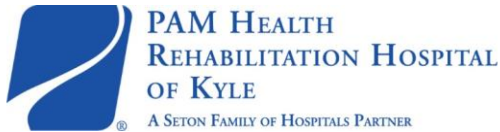
- Copies of 3 most recent paystubs from employer
- Copies of most recent yearly tax return (if self-employed, include all schedules)
- Social Security and/or Pension Retirement Award Letter
- Parent or Guardian's most recent yearly tax return, if applicant is a dependent listed on their tax form and under the age 25
- Copy of receipt of unemployment benefits
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance
- Other income validation documents

Examples of proof of assets include:

- Current bank statements (checking and savings accounts) from last 3 months
- Investments, including stocks and bonds
- Trust funds
- Money market accounts
- Mutual funds

If you receive assistance from or live in a home with a family or friends, please have them complete the attached form labeled "Letter of Support." This will not make them responsible for your medical bills. This will help show how you are able to afford living expenses. If you receive no assistance from family and friends, you do not need to fill out the Letter of Support form.

Finally, we may be able to consider your outstanding medical bills and qualify you for financial assistance. If you would like us to consider this, please also provide documentation of your outstanding monthly medical and pharmacy/drug costs, such as current invoices or statements of



account balances. **Please know that 1) completed application along with 2) proof of income, 3) assets, and 4) outstanding medical bills (if applicable) must be received in order for the application to be considered. We are unable to process or consider applications that are not complete.**

When submitting your application, please keep in mind that communications via email over the internet are not secure. Although it may be unlikely, there is a possibility that information you include in an email may be intercepted and read by other parties besides the person to whom it is addressed. We want to protect your personal information and ensure that it remains secure. Since the application contains your social security number and other private information, we urge you to refrain from emailing it.

Please print and mail or hand deliver your completed application to the following address:

PAM Health Rehabilitation Hospital of Kyle

5980 Kyle Parkway Kyle, TX 78640

Attn: Admissions

We are here to help and want to ensure that patients that qualify for financial assistance receive it. If you have any questions about this application, supporting documents required, or how to best get your application to us, please call one of our Patient Representatives at 512-262-0821.

Sincerely,

Patient Financial Services

PAM Health Rehabilitation Hospital of Kyle

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Financial Assistance Application Form

Patient Information

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application.)

Date: ______________________ Account Number: ___________________________________
Name (first and last): ____
Birth Date: ____________ Marital Status: _______________ Phone Number: ________________
Mailing Address: ______________________________________ City: _________ State: _______
Social Security Number (optional): ____
Employer: _____________________________________ Employment Status: ________________
Number of Hours Worked per Week: __________ Employer Phone Number: ________________

Responsible Party's Information/Legal Guardian's Information

(If patient above is the same as responsible party, leave this section blank.)

Name (first and last): ____
Birth Date: ____________ Marital Status: _______________ Phone Number: ________________
Mailing Address: ______________________________________ City: _________ State: _______
Social Security Number (optional): ____
Employer: _____________________________________ Employment Status: ________________
Number of Hours Worked per Week: __________ Employer Phone Number: ________________

Responsible Party Spouse Information

(If patient is same as responsible party, fill in spouse information for patient.)

Name (first and last): ____
Birth Date: ____________ Marital Status: _______________ Phone Number: ________________
Mailing Address: ______________________________________ City: _________ State: _______
Social Security Number (optional): ____
Employer: _____________________________________ Employment Status: ________________
Number of Hours Worked per Week: __________ Employer Phone Number: ________________

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Dependents of Responsible Party

(If patient is same as responsible party, fill in dependent information for patient.)

Name: ________________ Birth Date: _______ Relationship to Responsible Party: _____________
Name: ________________ Birth Date: _______ Relationship to Responsible Party: _____________
Name: ________________ Birth Date: _______ Relationship to Responsible Party: _____________
Name: ________________ Birth Date: _______ Relationship to Responsible Party: _____________
Number of Adults and Children Living in Household: ______________________________________

Monthly Income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant Earned Income: _______________
Applicant Spouse Income: _______________
Social Security Benefits: ________________
Pension/Retirement Income: _____________
Disability Income: _____________________
Unemployment Compensation: ___________
Worker's Compensation: ________________
Interest/Dividend Income: _______________

Child Support Received: _________________
Alimony Received: _____________________
Rental Property Income: _________________
Food Stamps: __________________________
Trust Fund Distribution Received: _________
Other Income: __________________________
Other Income: __________________________
Total Gross Monthly Income: $___________

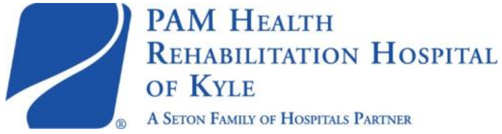
Monthly Living Expenses

Mortgage/Rent: ________________________
Utilities: ______________________________
Phone (landline): _______________________
Cell Phone: ____________________________
Groceries/Food: ________________________
Cable/Internet/Satellite TV: ______________
Car Payment: __________________________
Child Care: _____________________________

Child Support/Alimony: _________________
Credit Cards: ___________________________
Doctor/Hospital Bills: ____________________
Car/Auto Insurance: _____________________
Home/Property Insurance: _______________
Medical/Health Insurance: _______________
Life Insurance: __________________________
Other Monthly Expense: _________________
Total Monthly Expenses: $_______________

Assets

Cash/Savings/Checking Accounts: ____
Stocks/Bonds/Investments/CD(s): ____
Other Real Estate/Secondary Residence: ____
Boat/RV/Motorcycle/Recreational Vehicle: ____
Collector Automobiles/Non-Essential Automobiles: ____________________________________



Other Assets: ____

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Signature of Applicant ____________________________

Date____________________

Comments

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