INTEGRIS
Community Hospital

Dear Patient:

Attached you will find the INTEGRIS Community Hospital Financial Assistance Program Application. Completion of the application will enable us to consider the need for financial assistance for your medical bill(s). Applications must be resubmitted every six months. Applications must include total household income and total number of persons residing in the household.

We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential information. It will NOT be shared with anyone outside of INTEGRIS Community Hospital.

Please complete each item on the application. If you need additional space for any explanations, please utilize the back of the application. A credit report may be obtained to verify information given on this application. Photographed documents will not be accepted. All documentation provided shall become the property of INTEGRIS Community Hospital and cannot be returned to you.

Copies of all items listed below that are applicable to you must be provided so that a determination can be made for assistance. Self-prepared Taxes are not acceptable.

1. **Entire copy of the Previous Year Tax Transcript.**
   (For your Official IRS - Transcript -Call 1-800-908-9946).
   (This does not include W-2 forms or pay stubs)
2. **Entire copy of the Previous Year Tax Transcript and Social Security Award Letter. (Include spouse's income, if applicable).**
3. **Entire copy of the Previous Year Tax Transcript with Physician Disability Statement listing a permanent disability with documentation.**
4. **Any other documentation, as requested, to process your application.**

(If you no longer file taxes – you must provide the IRS Non-Filing document for the requirements listed above.)

****If-self-employed***, please provide a copy of your most recent filed personal income tax return and a current profit and loss statement, including all schedules that apply.

It is very important that you complete this application upon receipt and return it within 15 days. **The application will be reviewed within 30 days of receipt and you will be notified of a decision made within 60 days**. If you have any difficulty completing this application or have any questions, please contact our office at (877) 516-0911, Option 1. Office hours Monday - Friday 8:00am -5:00pm or submit to INTEGRIS Community Hospital Business Office located at 8686 New Trails Dr., The Woodlands, TX 77381

Your cooperation is appreciated.

Respectfully,

INTEGRIS Community Hospital Customer Service Department

INTEGRIS
Community Hospital

Financial Assistance Application

Facility:_____
Account #:_____
Guarantor #: _____

Patient Name: Last, _____ **First** _____ **Date of Birth** _____
Address: _____ **City** _____ **State** _____ **Zip** _____
Guarantor's Name: _____
Social Security #: _____

Married_____ Single_____ Divorced_____ Widowed_____
Do you have minor children (under 18)? Yes_____ No_____
Do they live with you? Yes_____ No_____
Are they your birth/legally-adopted children? Yes_____ No_____

Name of Employer

_____

Phone #_____
Address_____
Occupation_____

Name of Spouse's Employer

_____

Phone #_____
Address_____
Occupation_____

Income (Monthly Amount)	**Gross**	**Net**	**Family Members**
Patient	$_____	$_____	Child:_____ Age:_____
Spouse	$_____	$_____	Child:_____ Age:_____
Dependents	$_____	$_____	Child:_____ Age:_____
Public Assistance	$_____	$_____	Child:_____ Age:_____
Food Stamps	$_____	$_____	Child:_____ Age:_____
Social Security	$_____	$_____	Child:_____ Age:_____
Unemployment	$_____	$_____	
TOTAL	$_____	$_____	

Please provide any other information you feel would be helpful to us in determining your eligibility for assistance in paying your hospital bill(s).

_____
_____
_____
_____
_____

I understand INTEGRIS Community Hospital may verify the financial information contained in this application in connection with the evaluation of this application, and hereby authorize to contact my employer to certify the information provided and to request from the credit report agencies. I am aware this information will be used to determine my eligibility for charity assistance and falsifications. The information in this application is correct to the best of my knowledge. ***This application must be completed to process, if it is not it may be returned to the patient for completion.***

I further understand any reimbursement of medical expenses I receive relating to this hospitalization must be sent to INTEGRIS Community Hospital.

_____ _____
Signature of person making request Date

_____ _____
Signature of person making request, if not patient Relationship