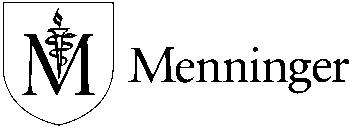
**Financial Assistance Application**



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| --- | --- | --- | --- | --- | --- | --- |
| Date of Application | | | Admissions Coordinator: | | | |
| Patient Name: | | | Guarantor Name: | | | ID #: |
| Patient Primary Phone: | | | Guarantor Primary Phone | | | |
|  | | |  | | | |
| **Admitting Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **Admitting Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| CPAS/ATP | \_\_\_ Compass\* | \_\_\_ Professionals\* | | \_\_\_ Hope\* | \_\_\_ Outpatient | |
| If CPAS: | \_\_\_ Readiness for Treatment\* | | | \_\_\_ Inpatient Comprehensive Assessment | | |
| If ATP: | \_\_\_ Long Term Treatment\* | | | \_\_\_ Diagnostic and Assessment | | |
| \* Services excluded from Financial Assistance - they do not meet medical necessity services, as defined in the Financial Assistance Policy. **Application is not approved**. | | | | | | |
| Inpatient Comprehensive Assessment for CPAS/ATP is a covered service. **Service Criteria is met.** | | | | | | |

**Annual Household Income** of the guarantor, as defined in the Financial Assistance Policy, as of the date of admission:

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| --- | --- |
| Is the patient a legal U. S. resident who resides in the state of Texas for at least 6 months? \_\_\_ Yes \_\_\_ No If not, **Application is not approved**. | |
| \_\_\_ Above $150,000 (May self-disclose income – no documentation needed.) | \_\_\_ Below $150,000 (Will need to provide documentation to support income.) |
| Income above $150,000 does not meet financial criteria, as defined in the Financial Assistance Policy. **Application is not approved.** | |
| If below $150,000, provide: Annual Income (including earnings from a job or self-employment and alimony income): \_\_\_\_\_\_\_\_\_\_\_ # in Household: \_\_\_\_ | |
| If annual household income is below $150,000, patient/guarantor must provide documentation to support income and number in household.  If documentation supports amounts listed above and income is greater than 400% PFL, **Application is not approved**.  If documentation supports amounts listed above and income less than 400% PFL, **Financial Criteria is met.** | |

I certify I have received a copy of The Menninger Clinic’s Financial Assistance Policy. I attest that, to the best of my knowledge and belief, all information in the attached Financial Assistance Application and supporting documents is complete and accurate. I understand that if incomplete or inaccurate information is provided or if any of these documents are falsified, the Menninger Clinic reserves the right to retroactively exclude me from financial assistance. I understand that I will be financially responsible for all charges, and the Menninger Clinic will follow its Billing and Collection policy.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor Signature (if different from Patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical Necessity Criteria:**

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| --- |
| Medical Necessity: Does the patient meet medical necessity, as determined by their referring outpatient provider? \_\_\_ Yes \_\_\_ No |
| Medical necessity and referral are required.If not, **Application is not approved.**  If Medical necessity is determined, **Clinical Criteria is met.** |

**Financial Presumptive Criteria:**

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| --- |
| \_\_\_ Is the patient active in a low-income program? If so list program: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Documentation/verification is required to support qualifications. **Financial Presumptive Criteria is met**. |

**Medically Indigent Criteria:**

|  |  |
| --- | --- |
| \_\_\_ Has the patient/guarantor made payments to Menninger in excess of 20% of their annual household income? | \_\_\_ Is the patient/guarantor currently making payments to another medical provider for prior healthcare services in excess of 20% of their income? |
| If yes to above, documentation is required to support payments and income. Payments will reduce the household income for the purpose of calculating financial criteria. If total income is over 300% FPL or revised income is more than 300% PFL **Additional review is required**.  If total income is under 300% FPL and revised income is less than 300% FPL **Additional review is not required**. | |

Financial Assistance Approved? \_\_\_ Yes \_\_\_ No If “No”, indicate reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- |
| Reviewed by: | | Date: | | Client Contacted by: | |
| Date Contacted: | Appt. Set: \_\_\_ Yes \_\_\_ No | | Date/Time: | | With Whom: |
| Re-evaluation due: | | | | | |