Menninger

Financial Assistance Application

Date of Application:	Admissions Coordinator:	
Patient Name:	Guarantor Name:	MCIS #:
Patient Primary Phone:	Guarantor Primary Phone:	

Admitting Unit: _____ Admitting Program: _____

___ CPAS/ATP	___ Compass*	___ PIC*	___ 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 is a covered service. **Service Criteria is met.**				

Annual Household Income, of the guarantor, as defined on the most recently filed federal tax return, as of the date of admission:

Is the patient a legal U. S. resident who resides in the Houston Metro area? ___ Yes ___ No If not, **Application is not approved**.	
Houston Metro area is defined as the following counties: Harris, Fort Bend, Montgomery, Brazoria, Galveston, Liberty, Waller, Chambers, Austin.	
___ Above $130,000 (May self-disclose income – no documentation needed.)	___ Below $130,000 (Will need to provide documentation to support income.)
Income above $130,000 does not meet financial criteria, as defined in the Financial Assistance Policy. **Application is not approved.**	
If below $130,000, provide: Annual Income (including earnings from a job or self-employment and alimony income): _____ # in Household: ____	
If annual household income is below $130,000, patient/guarantor must provide documentation to support income and number in household. If documentation supports amounts listed above and income is greater than 200% PFL, **Application is not approved**. If documentation supports amounts listed above and income less than 200% PFL, **Financial Criteria is met.**	

Medical Necessity: Does the patient meet medical necessity, as determined by their referring outpatient provider? ___ Yes ___ No
Medical Insurance Coverage: Does patient have current medical insurance coverage? ___ Yes ___ No
Medical necessity, referral, and medical insurance coverage are required, **Application is not approved.** If Medically necessary is determined and current medical insurance coverage is confirmed, **Clinical Criteria is met.**

Financial Presumptive Criteria:

___ 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 200% PFL **Application is not approved**. If total income is under 300% FPL and revised income is less than 200% FPL **Medical Indigent Criteria is met**.	

I certify I have received a copy of The Menninger Clinic's Financial Assistance Policy and that the information in this application is complete and accurate. I understand that if incomplete or inaccurate information is provided, that would have excluded me from financial assistance, the assistance will be revoked and I will be responsible for full payment of charges and the Clinic will follow its Billing and Collection policy.

Guarantor Signature: _____ Date: _____

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Service Criteria met? ___ Yes ___ No	Financial Criteria met? ___ Yes ___ No	Resident Criteria met? ___ Yes ___ No
Clinical Criteria met? ___ Yes ___ No	Financial Presumptive Criteria met? ___ Yes ___ No	Medical Indigent Criteria met? ___ Yes ___ No

Financial Assistance Approved?: ___ Yes ___ No If "No", indicate reason: _____

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