Financial Assistance Application

Date of Application: ___________________________ Admissions Coordinator: ___________________________

Patient Name: ___________________________ Guarantor Name: ___________________________ MCIS #: ___________________________

Patient Primary Phone: ___________________________ Guarantor Primary Phone: ___________________________

Admitting Unit: ___________________________ Admitting Program: ___________________________

<table>
<thead>
<tr>
<th>CPAS/ATP</th>
<th>Compass*</th>
<th>PIC*</th>
<th>Hope*</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If CPAS: ___________________________ Readiness for Treatment* ___________________________ Inpatient Comprehensive Assessment ___________________________

If AT: ___________________________ 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.

Admitting 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 annual household income is below $130,000, provide: Annual Income (including earnings from a job or self-employment and alimony income): ___________ # in Household: ___________
- If documentation supports amounts listed above and income is greater than 200% FPL, Application is not approved.
- 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 less than 200% FPL, 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% FPL, Application is not approved.

If documentation supports amounts listed above and 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: ___________________________

MENNINGER USE ONLY

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: ___________________________

Form Updated: 10/24/16