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:	___ Pain*	___ Readiness for Treatment*		___ Inpatient Comprehensive Assessments	
* 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 in the Financial Assistance Policy, as of the date of admission:

Is the guarantor a legal U. S. resident? ___ Yes ___ No If not a legal U.S. resident, **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 300% PFL, **Application is not approved**. If documentation supports amounts listed above and income less than 300% PFL, **Financial Criteria is met.**	

Medical Necessity: Medical Insurance Coverage:

Does the patient meet medical necessity? ___ Yes ___ No	Does patient have current medical insurance coverage? ___ Yes ___ No
Medical necessity and medical insurance coverage are required for financial assistance as defined in the Financial Assistance Policy. **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 400% FPL or revised income is more than 300% PFL **Application is not approved**. If total income is under 400% FPL and revised income is less than 300% FPL **Medical Indigent 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: ____ Date: ______________________

(DO NOT MARK BELOW THIS LINE)

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: 11/01/2020