US ANESTHESIA PARTNERS

Financial Assistance Application Form Instructions

This is an application for financial assistance for U.S. Anesthesia Partners (USAP) services. As part of our commitment to provide high quality care to all patients, USAP will honor or extend financial assistance to patients who satisfy certain requirements. The amount of assistance depends on a patient's annual income and family size. We understand your desire for privacy. Except for verification purposes, the information included in your application will be treated as confidential information.

Have you qualified for financial assistance with a facility or surgeon? If yes, then you must submit a copy of the financial assistance determination to the address below. No USAP application is required.

What does USAP financial assistance cover? Financial assistance is available to eligible patients who have received anesthesia care that is not covered by USAP contracted medical insurance or another direct contract with USAP.

Have questions or need help completing this application? The USAP Patient Advocacy Team is available at 833-479-0697 Monday-Friday 8:00 am to 5:00 pm. Copies of the USAP Financial Assistance Policy and Financial Assistance Application are available online at www.usap.com/patients/understanding-fees-and-billing at no charge. Copies may also be requested by mail at the address below.

In order for your application to be processed, you must:

- ☐ Provide information about you and any responsible party (guarantor).
- ☐ Provide information on your Annual Income (Note: gross income is income before taxes and deductions).
  - If the patient is an adult: total gross annual income of the patient and/or any other responsible party.
  - If the patient is married: total gross annual income of the patient and patient's spouse.
  - If the patient is a minor: total gross annual income of the parents/guardian, and/or any other responsible party.
- ☐ Provide proof of your Annual Income. If you have no proof of income or no income, please attach an additional page with an explanation. Proof of income examples include:
  - W-2 withholding statement
  - Current pay stubs (3 months)
  - Last year's federal income tax return, including schedules if applicable
  - Written, signed statements from employers or others
  - Approval/denial of eligibility for Medicaid and/or state-funded medical assistance
  - Approval/denial of eligibility for unemployment compensation
- ☐ Sign and date the financial assistance application

Expense and asset information is not required, however you may elect to provide this information to further demonstrate financial hardship and support your request for financial assistance.

You do not have to provide a Social Security number to apply for financial assistance. Social Security numbers are used to verify information provided and may help speed up the process of your application. If you do not have a Social Security number or do not wish to provide it, please mark "not applicable" or "NA."

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

Mail completed application with all documentation to the address below. Be sure to keep a copy for yourself.

USAP
Attn: Patient Advocacy Team
3705 Medical Parkway, Suite 570
Austin, TX 78705

We will notify you of the final determination of eligibility and appeal rights, if applicable, **within thirty (30) days** of receiving a complete financial assistance application, including documentation of income. **Please submit your application promptly. You may receive bills until we receive your information.**

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Financial Assistance Application

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Has the patient applied for Medicaid? ☐Yes ☐No

Does the patient receive public services such as TANF, SNAP, or WIC? ☐Yes ☐No

Is the patient currently homeless? ☐Yes ☐No

Is the patient's medical care need related to a car accident or work injury? ☐Yes ☐No

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security Number (optional): _____

Guarantor Name: _____ Relationship to Patient: _____

Guarantor Date of Birth: _____ Guarantor Social Security Number (optional): _____

Mailing Address: _____

Phone Number: _____ Email Address: _____

Service(s) and Date(s) Requested for Assistance: _____

Employment Status of Patient (or Guarantor if applicable):

☐Employed Full Time ☐Employed Part Time ☐Unemployed (how long:_____)

☐Self-Employed ☐Student ☐Disabled ☐Retired ☐Other (_____)

INCOME INFORMATION

Number of people in your household: _____

Name	Employer(s) name or source of income*	Total gross monthly income (before taxes)
Patient		
Spouse		
Guarantor		

*Includes all wages, farm or self-employment, public assistance, social security, unemployment/worker's compensation, retirement, strike benefits, alimony, child support, military allotments, pensions, incomes from dividends, interest, rental property and other miscellaneous income sources.

EXPENSE INFORMATION

List all monthly household expenses:

Rent/Mortgage $_____ Medical Expenses $_____

Automobiles $_____ Utilities $_____

Other Debt/Expenses $_____ (including child support, loans, etc)

ASSET INFORMATION

List any additional assets your family may have:

Current checking account balance $_____ Current savings account balance $_____

Please check all that apply: ☐Stocks ☐Bonds ☐401K ☐Health Savings Account(s) ☐Trust(s)

☐Property (excluding primary residence) ☐Own a business

PATIENT AGREEMENT

I understand that U.S. Anesthesia Partners may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans. I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

Patient/Guarantor Signature: _____ Date: _____