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. Except for verification purposes, the information included in your application is confidential.

You may be automatically eligible for financial assistance in some situations. **NO APPLICATION NEEDED IF:**

- You **received financial assistance/charity from the facility or surgeon**. You must submit a copy of the determination letter and your USAP statement/account information to the address below.
- You **qualify for Medicaid or public services such SNAP, WIC or TANF**. You must submit a copy of the eligibility determination and your USAP statement/account information to the address below.
- **You have been approved for USAP financial assistance in the past 90 days**. Please contact USAP Patient Advocacy at 833-479-0697 with your statement/account information.

For all other situations, please complete an application and provide supporting documentation.

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 CST. Copies of the USAP Financial Assistance Policy and Application are available online at www.usap.com/patients/understanding-fees-and-billing at no charge.

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 or guarantor.
  - 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, or guarantor.
- ☐ Provide proof of your annual Income. Proof of income examples include:
  - Most recently filed federal income tax return
  - Most recent W-2 or 1099 forms
  - Current pay stubs (3 months)
  - A statement from your employer if paid in cash
  - Any other verification from a third party regarding annual income (ex: 3 months bank statements, current unemployment eligibility, social security, alimony, child support, etc.)
- ☐ Sign and date the financial assistance application

If you feel you have extraordinary expenses or circumstances that cause financial hardship, you may provide this information to support your request for financial assistance. Please attach appropriate documentation.

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 **within thirty (30) days** of receiving a complete financial assistance application. **Please submit your application within thirty (30) days. You will remain responsible for your balance until this application is received and processed.**

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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.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Guarantor Name: _____ Relationship to Patient: _____

Guarantor Date of Birth: _____

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*: _____

*Household is defined as the patient or guarantor and any individuals who are claimed as dependents for federal taxes. This may include a spouse and/or dependents such as children.

Name	**Employer(s) or source of income***	**Gross annual income (before taxes)**
Patient:		
Spouse:		
Guarantor:		
*All wages, including self-employment, public assistance, social security, unemployment, worker's compensation, retirement, strike benefits, alimony, child support, military allotments, pensions, etc. **You must provide proof of all income listed.**		

PATIENT AGREEMENT

I understand that U.S. Anesthesia Partners may verify information provided here by reviewing credit information or obtaining information from other sources to assist in determining eligibility for financial assistance. 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: _____