Carrell Care Community Partners

2023 Platinum Transparency Rating on Candid/GuideStar
Four-star Charity on Charity Navigator

Carrell Care Community Partners Financial Assistance Application

Patient Name (Last, First, MI) _____ Social Security Number _____

Patient Address _____ City _____ State _____ Zip Code _____

Birth Date (Month/Date/Year) _____ Telephone Number _____

Marital Status: o Married o Single o Widowed o Separated o Divorced

Spouse's Name _____

Ethnicity: o Hispanic or Latino
o Not Hispanic or Latino

Race: o American Indian or Alaska Native
o Asian o Black or African American
o Native Hawaiian or Other Pacific Islander
o White o Other

Employed o Yes o No

Spouse's Employer _____

Telephone # _____

Employed o Yes o No

Patient's Employer _____

Telephone # _____

If unemployed, please include the previous employer's name and telephone number*

A. *Income:* Please provide the income for each of the following persons in your household.

Patient o Full Time o Part Time - Hours/Week = _____
$ _____ o Hr o Wk o Bi-Wk o Month o Year

$ _____ **Additional Income**

Spouse o Full Time o Part Time - Hours/Week = _____
$ _____ o Hr o Wk o Bi-Wk o Month o Year

$ _____ **Additional Income**

Total Household Income $ _____

Please complete only if patient is a minor (if not leave blank)

Patient's Father o Full Time o Part Time - Hours/Week = _____
$ _____ o Hr o Wk o Bi-Wk o Month o Year

$ _____ **Additional Income**

Patient's Mother o Full Time o Part Time - Hours/Week = _____
$ _____ o Hr o Wk o Bi-Wk o Month o Year

$ _____ **Additional Income**

Total Household Income $ _____

B. *Income Verification:* Please provide verification ***(send only copies, no original documentation)*** for all sources of household income (acceptable documentation listed below). Check attached documents:

o Paycheck Remittance o Employer Verification o Credit Inquiry (completed by CC Foundation)
o IRS Form W-2 o Tax Return o Governmental Assistance (food stamps, CDIC, Medicaid, TANF)
o Bank Statements o Other (describe below) o Social Security, Workers Compensation or Unemployment Compensation Determination Letters

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

_____

C. *Family Members:* Please provide the total number of people in the patient's household.
(This number should only include the patient, patient's spouse, and the patient's dependents) _____

D. *Assets and Other Resources:*

Do you have any assets or other resources available to you? ☐ Yes ☐ No If Yes, current amount available: $_____
(Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)

Do you have medical insurance? ☐ Yes ☐ No If Yes, please list provider name: _____

Do you have a Health Savings Account or Flexible Spending Account? ☐ Yes ☐ No If Yes, current amount available: $_____

I understand Carrell Care Community Partners may verify the financial information contained in this Financial Assistance Application ("Application") in connection with the Carrell Care Community Partners' evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize Carrell Care Community Partners to request background checks, credit reports, and Social Security Administration verification. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance. I further understand that some physicians and providers may not be contracted with Carrell Care Community Partners. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

Signature of Patient or Responsible Party _____ **Printed Name** _____ **Date** _____

For Carrell Care Community Partners' Use Only		
Application information obtained by Carrell Clinic Foundation representative in person or over the phone, no patient signature required.	Electronic Signature of Carrell Care Community Partners representative	Date
Notes Regarding Income Verification/Number in the Household:		

carrellclinicfoundation.org 214-712-4200

INSTRUCTIONS FOR HARD COPY OF FORM

CARRELL CARE COMMUNITY PARTNERS APPLICATION INSTRUCTIONS

Please fill in all questions asked on the Financial Assistance Application. In addition, we must receive written documentation of your income along with a letter or email stating your medical history/current medical need and exactly for what you are requesting financial assistance.

Please note that we cannot consider your application until we receive income verification documentation and the details of your need.

Please send the required documentation either by mail, email or fax to:

Carrell Care Community Partners
Attn: Dana Martinez
9301 N. Central Expressway
Tower 2, Suite 335
Dallas, TX 75231

Email: dana@carrellclinicfoundation.org

Fax: 214.720.1982

INSTRUCTIONS FOR FILLABLE FORM

CARRELL CARE COMMUNITY PARTNERS APPLICATION INSTRUCTIONS

The application is a fillable form. Please fill in all questions asked and click on the "Submit" button. In addition, we must receive written documentation of your income along with a letter stating your medical history/current medical need and exactly for what you are requesting financial assistance. If you prefer to print the application and fill it in by hand, you can submit it at the same time you submit all required documentation. **Please note that we cannot consider your application until we receive income verification documentation and the details of your need.**

Please send the required documentation either by mail, email or fax to:

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