APPLICATION CHECK LIST

Full application includes:

- Patient Information Form
- Household & Family Financial Profiles
- Employment/Salary Verification. This form must be signed by the employer
- Methodist Healthcare System Financial Assistance Application. Complete all areas and send the specific documents requested.
- Acknowledgement of Privacy Practices
- Medical Release Form

Financial Documentation Required

- Most Recent IRS Tax Return
- Most recent pay stub (if applicable) or a notarized letter stating your means of financial support
- Copy of recent Utility Bill
- Copy of Photo ID
- Social Security Card or proof of TIN
- COBRA Election form (if applicable)

We also require that you furnish the following medical records

- All pathology reports relating to your diagnosis of breast cancer
- All reports from mammogram, ultrasound or other screening procedure
- Physicians' notes and dictation relating to the diagnosis and/or treatment of breast cancer

Original forms must be mailed back to WINGS. No fax or electronic copies will be accepted.

WINGS
ATTN: Patient Navigator
7500 Highway 90 West, Building 2, Ste. 240
San Antonio, Tx. 78227

After we receive your completed application package, it will take approximately one week to review and process your application. We also require that you apply for Medicaid benefits and provide your letter of denial to us within 60 days. If you applied to Medicaid within the past 3 months, please send a copy of your determination letter along with your packet.

If approved, you will be sent an Identification Card that you must present to all participating provider offices.

Application sent to client: _____

PATIENT INFORMATION FORM

PLEASE PRINT

Name: _____
First Middle Initial Last

Address: _____
Street City State Zip

Home Phone: (___) _____ Work Phone: (___) _____

Date of Birth: _____

If you have a Social Security Number, please list it here: _____

Current County where you are living: _____

CIRCLE ALL THAT APPLY TO YOU

Single-parent Household Two-parent Household Head of Household

Number of Children: _____ Marital Status: Married Single Divorced Widowed

Ethnicity: African American Anglo Hispanic Native American Other

Primary Language: English Spanish Both Other

Do you have medical insurance? Yes No

If yes, list Insurance Carrier. _____ Policy # _____
Carrier Phone #: _____ Effective Date: _____
PLEASE INCLUDE A COPY OF YOUR INSURANCE POLICY WITH THIS APPLICATION.

Are you eligible for Medicaid? Yes No Don't know
If you have been denied for Medicaid, please state reason for denial. _____

BREAST CANCER QUESTIONNAIRE

Have you been diagnosed with breast cancer? Yes _____ No _____
Date of diagnosis _____

Have you had breast cancer surgery? Yes _____ No _____
Date of surgery _____

Have you ever received Chemotherapy? Yes _____ No _____
Please indicate the date of your most recent chemotherapy treatment _____
Have you completed all of your prescribed chemotherapy? Yes _____ No _____

Have you ever received Radiation Therapy? Yes _____ No _____
Please indicate the date of your most recent radiation treatment _____

HOUSEHOLD PROFILE

Name	Relationship	Date of Birth	Social Security #	Education Completed	Code

EMPLOYMENT CODE: Current employment State of Each Household Member

A = Employed Full Time **B** = Employed Part Time **C** = Unemployed/Able to Work
D = Unemployed/Retired **E** = Unemployed/Disabled **F** = Student **G** = Other

FAMILY FINANCIAL PROFILE

Include information for all adults in the home

Monthly Income		**Monthly Expenses**	
Salary/Wages	$	Rent/Mortgage	$
AFDC/Food Stamps	$	Utilities (electric, gas, water, phone)	$
Social Security	$	Food	$
SSI	$	Car Payment	$
VA	$	Gasoline	$
Investment Income	$	Car Insurance	$
Rental Property Income	$	Life Insurance	$
Other	$	Health Insurance	$
Other	$	Medical Expenses	$
		Other	$
TOTAL	**$**	**TOTAL**	**$**

Please provide any other information regarding your income, expenses or assets that you would like for us to know. _____

I certify that the information I have provided is true and complete. By signing below I also agree that I will notify WINGS if I become covered by insurance (including Medicaid or Medicare) or if there is a significant change in my household income. I understand the information I submit concerning my annual income and family size is subject to verification by WINGS. I also understand that if the information is determined to be false, such determination will result in a denial of my application and I will be liable for all charges on any services provided.

PRINT NAME SIGNATURE DATE

WINGS EMPLOYMENT/SALARY VERIFICATION

This form is to be completed and signed by the applicant's employer or supervisor.

Employee Name: _____ Date of Birth: _____

Date of Hire (Month/Year): _____ Job Title: _____

Is this person currently employed? Yes _____ No _____

If not, dates of prior employment (Month/Year): From _____ To _____

Full Time _____ Part Time _____ Permanent _____ Temporary _____

Average Hours Per Week: _____

Rate of Ray: $_____ per _____Hour _____ Day _____ Week ____ Month ____ Job

Commissions/Tips/Bonuses: _____ Please describe: _____

_____

Overtime: ____ Frequently _____ Rarely _____Never FICA/FIT Withheld: ____ Yes _____ No

Health Insurance Available? _____ Yes _____ No
If yes, is employee enrolled: _____ Yes _____ No
If no, when is employee next eligible to enroll: _____

Is employee eligible for Leave With Pay? _____ Yes _____No
If Yes, length of time allowed: _____

In the chart below, list all wages received by this employee during the past three months.

Pay Period Dates	Hours Worked	Gross Pay	Additional Pay (tips, commission, etc.)

THIS INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Printed Name & Job Title: _____
Signature & Date: _____
Name of Company or Employer: _____
Address & Telephone Number: _____
_____

Methodist Healthcare System Financial Assistance Application

Patient Name _____ Patient Account Number _____

Telephone Number _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

☐ Employed
☐ Unemployed

Employer (Name, Address and Telephone Number) _____

Spouse Name _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

Patient's Father (If patient is a minor) _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

Patient's Mother (If patient is a minor) _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

A. ***Wages:*** Please provide the wages for each of the following persons in your household.

		Circle One				Circle One
Patient	$_____	Hr/ Wk/ Month/ Year	Patient's Father (if patient is a minor)	$_____	Hr/ Wk/ Month/ Year	
Spouse	$_____	Hr/ Wk/ Month/ Year	Patient's Mother (if patient is a minor)	$_____	Hr/Wk/ Month/ Year	

B. ***Other Resources:*** Please provide the total amount of other resources available to you, including savings accounts, checking accounts, stocks, bonds, etc. $ _____

Please provide the amount of yearly income you receive from these other resources, including interest income, dividends, rental income, etc. $ _____

C. ***Family Members:*** Please provide the number of persons in the patient's household. _____

D. ***Income Verification:*** Please provide any of the following types of documentation to verify your income.

- IRS Form W-2
- Paycheck Remittance
- Tax Return
- Bank Statements
- Employer Verification
- Proof of Participation in Governmental Assistance programs such as food stamps, CDIC, Medicaid or AFDC
- Social Security or Unemployment Compensation Determination Letters
- Other, Please Describe

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

_____

I understand Methodist Healthcare System (MHS) may verify the financial information contained in this Financial Assistance Application ("Application") in connection with MHS' evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize MHS to request reports from credit reporting agencies and the Social Security Administration. I certify that this information is true to the best of my knowledge and I am aware that falsification of information on this Application may result in denial of financial assistance.

_____ Date _____
Signature of Patient or Responsible Party

_____ Date _____
MHS Employee Signature if any part of Financial
Assistance Application Completed by an MHS Employee

RELEASE OF MEDICAL INFORMATION AND DISCLOSURE

o I hereby request that _____ send copies of my medical information to:

WINGS (Women Involved in Nurturing, Giving, Sharing Inc.)
7500 Highway 90 West, Bldg. 2 Suite 240
San Antonio, Texas 78227
Fax: 210-733-5260

o I hereby request that _____ provide me copies of the information below. I will deliver the information to WINGS (Women Involved in Nurturing, Giving, Sharing Inc.) and I will be responsible for the privacy of the copies.

Information requested:

o I authorize WINGS (Women Involved in Nurturing, Giving, Sharing Inc.) to provide my personal, financial or any other information as needed for the processing of my enrollment in designated Pharmacy Assistance Programs to my prescribing physicians.

o I authorize WINGS (Women Involved in Nurturing, Giving, Sharing Inc.) to use my personal, financial or any other information necessary for my enrollment in designated Pharmacy Assistance Programs.

o I have been given the opportunity to ask questions about the services and all of my questions have been answered to me satisfaction. I have received a copy of the WINGS privacy notification dated September 2, 2003.

Patient's Name _____

_____ _____
Patient's or Legal Guardian's Signature Date

Please return a signed Release of Medical Information and Disclosure form in the WINGS envelope provided and keep a copy for your records.

Received Release of Medical Information and Disclosure by WINGS

on _____ by _____

This form is to be filed in the permanent patient record at WINGS.

WINGS NOTICE OF PRIVACY PRACTICES

This notice describes how medical and financial information about you can be used and disclosed and how you can get access to this information. Please read it carefully.

This "Notice of Privacy Practices" is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. **You will be asked to acknowledge receipt of this notice.** Our intent is to make you aware of the disclosures of your protected health information and privacy rights. If you decline to sign the acknowledgement, we will continue to provide services, however, we will disclose your protected health information when authorized by law.

Our Duty: We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We are required to abide by the terms of this notice, however, we reserve the right to change this notice. This notice will be effective on September 2, 2003, and applies to health information we already have about you, as well as any information we receive in the future. You may obtain a "Notice of Privacy Practices" from Women Involved in Nurturing, Giving, Sharing Inc. (WINGS) at 7500 Highway 90 West, Bldg. 2 Suite 240, San Antonio, Texas 78227 or from the WINGS website, www.texaswings.org.

Your Rights: You may exercise the following rights by submitting a written request to the WINGS Privacy Officer. The WINGS Privacy Officer is Terri Jones, executive director.

Right to Inspect and Copy: You may inspect and obtain a copy of your protected health information that is in your medical record for as long as we maintain the record. *Be aware that there is an established fee for making copies of your medical record.* This right does not include inspection and copying information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and when access to protected health information is prohibited by law.

Right to Request Restrictions: You may ask us not to disclose any part of your protected health information. Requests should be noted on the "Authorization for Release of Medical Information."

Right to Request Confidential Communications: You may request that we communicate with you using an alternative means. We will accommodate your request, if possible.

Right to Request Amendment: If you believe the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain the information.

Right to Account Disclosures: You may request, in writing, a list of the disclosures we have made in your protected health information. The disclosures must have been made after September 2, 2003, and no more than six (6) years prior to the date of request. This right applies to disclosures other than those listed on the next page. Other uses and disclosures will be made only with your written authorization and you make revoke this authorization, in writing, at any time.

- We may use and disclose your protected health information to coordinate or manage your treatment/services. This includes hospitals, clinics, physicians, other health care providers/clinicians, pharmacy assistance programs, which may become involved in your care or services you receive.

- We may use and disclose your protected health information to obtain payment for your treatment/services. This includes activities WINGS performs prior to coordinating care, such as determining eligibility or coverage for benefits and reviewing services provided for your medical necessity. An example is determining eligibility for WINGS services.

- We may use or disclose your protected health information to coordinate activities for other health care-related activities. For example, we may contact you to provide information about treatment alternatives or other health-related benefit services that may be of interest to you.

- We may use or disclose your protected health information to your family involved in your care or for emergency notification.

Right to Obtain a Copy of this Notice: You may obtain a "Notice of Privacy Practices" from Women Involved in Nurturing, Giving, Sharing Inc. (WINGS) at 7500 Highway 90 West, Bldg. 2 Suite 240, San Antonio, Texas 78227 or from the WINGS website, www.texaswings.org.

Complaints: If you believe your privacy rights have been violated, you may submit a written complaint to the WINGS Privacy Officer. No retaliation will occur against you for filing a complaint.

Submit questions or comments to our Privacy Officer:

Terri Jones
Executive Director
WINGS
7500 Highway 90 West, Bldg. 2 Suite 240
San Antonio, Texas 78227
210-946-9464
210-722-5260 (fax)

ACKNOWLEDGEMENT
RECEIPT OF PRIVACY PRACTICES
WINGS

By signing below, I acknowledge that I have received the *Notice of Privacy Practices* from WINGS, (Women Involved in Nurturing, Giving & Sharing).

_____
Printed Name

_____
Signature

_____
Date