Llano Regional Hospital

FINANCIAL ASSISTANCE APPLICATION

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
MRN Number

Form content not retained in medical record
For local storage only.

Instructions: Complete application and attach copies of:

- Tax return from current or prior year (or W-2 if tax not available)
- Unemployment statements (if applicable)
- Pay stubs (most recent month)
- Social security, pension, retirement benefits (if applicable)
- Bank statements (most recent month for all accounts)

If the above copies are not available, provide a separate page describing your current financial situation.

Patient of Responsible Party Completing This Application

Patient Name (First Middle Last)		Birth Date (mm-dd-yyyy)	
Address	City	State	ZIP Code
Responsible Party Completing the Application (if not the Patient) (First Middle Last)		Relationship to the Patient (if not the Patient)	
Household Annual Income (as reported on income tax filing)	Household Size (patient, spouse, and dependents as reported on income tax filing)		
Phone	Medical Insurance Name and Policy Number		
Employment Status ☐ Full time ☐ Part time ☐ Self employed ☐ Unemployed ☐ Student ☐ Retired		Employer Name	
Employment Length	Unemployed Date/Length (mm-dd-yyyy)	Are you claimed on another tax return? ☐ Yes ☐ No (if "Yes," provide tax return.)	

Dependents (if more than 6 dependents, use separate page)

Full Name (First Middle Last)	Relationship	Birth Date (mm-dd-yyyy)
1.		
2.		
3.		
4.		
5.		
6.		

Spouse (Used to identify all patient accounts eligible for financial assistance)

Marital Status		
Name (First Middle Last)		Birth Date (mm-dd-yyyy)
Employment Status ☐ Full time ☐ Part time ☐ Self employed ☐ Unemployed ☐ Student ☐ Retired	Employer Name	
Employment Length	Unemployed Date/Length (mm-dd-yyyy)	

FINANCIAL ASSISTANCE APPLICATION (continuted)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
MRN Number

Certification Signatures

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by Llano Regional Hospital or an affiliated entity and I give permission to Llano Regional Hospital and all affiliated clinics, hospitals and entities to share the information as necessary to consider my financial assistance request. I hereby grant permission to Llano Regional Hospital and all Llano Regional Hospital affiliates and representatives of agents to investigate the information contained herein.

Patient or Responsible Party Signature ▶	Date (mm-dd-yyyy)
Responsible Party Printed Name (First Middle Last)	

EXHIBIT C

Medical Financial Assistance Discount (for 2025) Income Ranges)						
	Sliding Scale Discount based on FPL					
	100%	80%	60%	40%	20%	0%
Family Size	Base Income Guidelines					
1	$ 62,600	$ 71,990	$ 81,380	$ 90,770	$ 100,160	$ 109,550
2	$ 84,600	$ 97,290	$ 109,980	$ 122,670	$ 135,360	$ 148,050
3	$ 106,600	$ 122,590	$ 138,580	$ 154,570	$ 170,560	$ 186,550
4	$ 128,600	$ 147,890	$ 167,180	$ 186,470	$ 205,760	$ 225,050
5	$ 150,600	$ 173,190	$ 195,780	$ 218,370	$ 240,960	$ 263,550
6	$ 172,600	$ 198,490	$ 224,380	$ 250,270	$ 276,160	$ 302,050
7	$ 194,600	$ 223,790	$ 252,980	$ 282,170	$ 311,360	$ 340,550
8	$ 216,600	$ 249,090	$ 281,580	$ 314,070	$ 346,560	$ 379,050
9	$ 238,600	$ 274,390	$ 310,180	$ 345,970	$ 381,760	$ 417,550