PATIENT BENEFIT
FOUNDATION

PATIENT APPLICATION FORM

Dear Applicant,

Thank you for your interest and trust in Patient Benefit Foundation.

At PBF, our mission is to improve access to medically necessary elective surgical care by providing financial assistance to eligible uninsured and underinsured individuals who cannot afford the full cost of an elective surgical procedure.

Completing this application will allow PBF to review your request for financial assistance. To determine your eligibility, please complete this application and submit it with the required supporting documentation listed below:

- A completed Patient Application Form and the No Income Affidavit (If applicable)
- All applicable documents listed on the Pre-Qualification Documents Checklist.
- A signed Waiver of Liability Form
- A signed Photograph and Video Release Form (voluntary)

Please complete every section of this application as thoroughly and accurately as possible. If you need additional space for any response, you may attach separate sheets. If you have questions or need assistance completing the application, please contact the PBF office during normal business hours.

We have included the "Patient Application Process and Qualification" document to provide an overview of our application process. As part of our mission, we encourage patients who receive assistance through PBF to share their experience by participating in a testimonial video. These stories help raise awareness of our organization and enable us to assist more patients in need. Participation is entirely voluntary and is not required for consideration of financial assistance.

Your cooperation is greatly appreciated. Please note that **submission of a completed application and all required documentation does not guarantee approval for financial assistance.** Assistance is subject to eligibility requirements, verification of the information provided, available funding, and final approval by PBF. Applicants remain financially responsible for any medical expenses that are not approved or paid by PBF.

Completed applications and supporting documentation may be submitted by email to:

Email: surgery@pbfusa.org

Phone: (800) 936-0074
Address: 1 Sugar Creek Center Blvd., Suite 618
Sugar Land, TX 77478

Sincerely,
Patient Benefit Foundation

PLEASE PRINT CLEARLY

Patient Name (Last, First, Middle)	Date of Birth	Phone Number	Alternate Phone Number

Home Address	Email Address	Gender	Preferred Language

Mailing Address (If different from Home Address)	City	State	Zip

Marital Status: ☐Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated (Requires documentation of separate addresses for 2 Years)

What is your legal status in the United States? (Please Check One)

- ☐ US Citizen
- ☐ Lawful Permanent or Conditional Resident until (expiration date): _____
- ☐ An Alien Authorized to Work until (expiration date): _____
- ☐ Student (F-1 Visa) until: _____
- ☐ Business Visitor or Tourist (B1/B2 Visa) until: _____
- ☐ Fiancée (K1 Visa) until: _____
- ☐ Refugee/Temporary Protected Status
- ☐ Undocumented (Unfortunately, you are NOT a qualifying candidate.)

Social Security Number	Driver's License Number	Driver's License State	Expiration Date

Alien Registration/USCIS/Visa /I-94 Admission Number:	Foreign Passport Number and Expiration Date:

What is the medical condition that you are seeking treatment for?	Date of Illness/Injury/Accident

ANSWER EVERY QUESTION. Write "NA" if the question does not apply. This application should be completed by or for the patient.

1. **List everyone who lives with you or is part of your household, whether you consider them household members or not, including the patient.**

NAME Last First Middle	AGE	RELATIONSHIP	EMPLOYED Y N	STUDENT Y N	MARRIED Y N	DISABLED Y N
		PATIENT				

2. **Are you (patient) covered by any private or government health insurance?** ☐Yes ☐No

(If "Yes", complete the following items about private health insurance)

Insurance Company Name		Name of Policy/ Subscriber Holder
Insurance Member ID	Group Number	Provider Services Phone Number
Referring Physician/Facility		Referring Physician/Facility Phone #
Employment Related	If "Yes", Employer Name	
Individual/Family Deductible*	Amount of Deductible Met*	Remaining Deductible
Annual Out-of-Pocket Maximum	Out-of-Pocket Amount Met to Date	Remaining Out-of-Pocket Maximum

**As a nonprofit foundation, PBF prioritizes cost-effectiveness to extend support to more patients. Therefore, for insured patients, we cover either insurance deductible or the entire surgical expenses, opting for the lower cost option.*

Does the insurance cover the requested surgery?

☐ Yes, fully ☐ Yes, partially ☐ No ☐ Unknown

Has coverage for the requested surgery been denied or limited?

☐ Yes ☐ No ☐ Appeal pending

If yes, explain or attach denial/coverage documentation:

_____

_____

3. **Have you (patient) been covered during the last 3 months by any health insurance policy under which you are no longer covered?** ☐Yes ☐No

(If "Yes", complete the following)

Insurance Company Name	Name of Policy/ Subscriber Holder	
Employment Related? ☐Yes ☐No	If "Yes", Employer Name	Ending Coverage Date

Have you applied for or received assistance from another organization, hospital, government program, or charity for this surgery? ☐ Yes ☐ No

If yes, then fill below,

Organization/Program: _____ Amount approved or received: _____

4. **Do you (patient) or anyone who lives with you have a job (including day work, babysitting, etc.) or are any of you in training for a job? ☐Yes ☐No**

(If "Yes", fill out the blanks for each person who is in training or is employed (including self-employment) If "No" attach the no Income Affidavit"

Name of Person Working	Name of Employer/Occupation	Hourly Rate/Salary	Hours/Week	Pay Frequency*	Gross Monthly Income

*pay frequency could be Daily, weekly, biweekly or monthly.

5. **Do you (patient) or anyone else in your household receive money from the following sources? (Write "Y" or "N", if "Y, List Gross Amount per Month):**

Income Source	Y	N	Gross Monthly Amount
Social Security			$
SSI/SSDI			$
Veterans Benefits/Pensions			$
Retirement/Pension			$
Unemployment Benefits			$
Workers' Compensation			$
Private Insurance Payments			$
Child Support/Alimony			$
Rental Income			$
Interest/Dividends			$
Cash/Gifts/Family Support			$
Educational Loans/Grants/Scholarships			$
Short-Term Disability			$
Long-Term Disability			$

Income Source	Y	N	Gross Monthly Amount
Money from Roomers or Boarders in Your House			$
Welfare Checks (AFDC)			$
Dividends from Stocks and Bonds			$
Food Stamps			$
Other Income			
			$
			$
			$
			$

6. **List your (patient) monthly expenses below:**

	Amount
Rent or House Payments	$
Utilities (gas, Electric, etc)	$
Telephone/ cable/ Internet	$
Credit Card Accounts	$
Car Payments	$
Home/Car Insurance Payments	$
Gasoline	$
Food	$

	Amount
Taxes, Special Assessments	$
Loans	$
Child Care	$
Medical Expenses	$
Other Expenses	
	$
	$
	$

7. **Do you (patient) or anyone who lives with you have any of the following Assets, write ("Yes" or "No", if "Yes", give value):**

Asset	Yes/No	Estimated Value
Checking Accounts		$
Savings Accounts		$
Cash		$
Stocks/Bonds/CDs		$
Retirement Accounts/IRAs		$
Real Estate/Rental Property		$
Vehicles/Boats/Other Motor Vehicles		$
Life Insurance		$
Other Significant Assets		$

8. **Are you (patient) currently applying for Medicaid benefits? ☐Yes ☐No**

9. **Are there any potentially liable third parties responsible of any accident/injury/illness? (check "Yes" or "No" for each)**

Auto Insurance	Commercial Insurance	Residential Insurance	Worker Compensation	Other	Victim of Crime
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

If "Yes", complete the following items about personal/auto/liability insurance and attach an additional page with details of the accident.

Insurance Company Name		Responsible Party	
Claim Number	Date of Injury	Adjuster/Case Worker	Phone

10. **Please give the following information for your surgery, write N/A where not applicable.**

Name of Elective Surgery/Procedure:	Treating Surgeon/Physician
Medical Practice/Clinic	Hospital or Surgical Facility
Proposed Surgery Date	Is the surgery currently scheduled? ☐ Yes ☐ No
How does the condition affect your daily life, work, mobility, function, or other important activities?	
What may happen if the surgery is delayed or cannot be obtained?	

11. **Please explain the circumstances that prevent you from paying for the requested elective surgery.**

_____

_____

I certify that the information provided in this application and all supporting documents is true, accurate, and complete to the best of my knowledge. I understand that PBF may verify the information provided and may request additional documentation reasonably necessary to evaluate my application.

I understand that submission of this application does not guarantee approval. PBF assistance is subject to eligibility requirements, verification, available funding, and final approval.

I authorize PBF, for the limited purpose of evaluating and administering this application, to contact relevant healthcare providers, surgical facilities, insurance companies, employers, government benefit agencies, and other parties directly related to this application as reasonably necessary to verify information or coordinate approved assistance.

I understand that falsification, material omission, or misrepresentation may result in denial, withdrawal, or reversal of financial assistance. I understand that PBF may pay approved assistance directly to healthcare providers or facilities.

Signature of Patient/Responsible Party (Relationship to Patient) Date

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FOR PBF USE ONLY

Application ID:	**Date Received:**
Reviewed By:	
Application Status: ☐ Complete ☐ Incomplete — Additional Documentation Requested ☐ Under Review ☐ Approved	☐ Partially Approved ☐ Denied ☐ Withdrawn
Eligibility Review: ☐ Uninsured ☐ Underinsured ☐ Financial hardship demonstrated	☐ Medical/provider documentation complete ☐ Surgery cost estimate complete ☐ Additional verification required

Approved Amount: $ _____

Decision Notes:

_____

_____

_____

_____

Authorized PBF Representative: _____

Signature: _____

Date: _____