



Hospital Financial Assistance Application

Date _____ Clerk _____ Account # _____

Last Name _____ First Name _____ Middle _____

Social Security # _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____ Phone _____

Mailing Address if Different from Street Address _____ How Long _____

Present Employer _____ Employment Date _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

Present Salary¹ _____ Number of Dependents _____ Ages of Dependents _____

Spouse's Name _____ Present Salary _____ SS# _____

Present Employer _____ Employment Date _____ Phone _____

Other Income _____ Have you applied for State/Federal Aid? (Yes) _____ (No) _____

If Yes, When and Type: _____

Monthly Expenses: Rent/Mortgage \$ _____ Medical \$ _____ Food/Utilities \$ _____ Other \$ _____

<i>Listing of Asset² (use additional sheet if necessary)</i>	<i>Market Value</i>	<i>Outstanding Debt/Liability</i>	<i>Net Value (Market Value less Debt)</i>
Banking Accounts: Name of Bank: _____ Checking Balance: \$ _____ Savings or Investments Balance: \$ _____ Retirement/Brokerage Accounts Balance: \$ _____		N/A	N/A
Primary dwelling (if owned or purchasing)	\$ _____	\$ _____	\$ _____
Automobiles Auto 1 Yr/Make/Model: _____ \$ _____	\$ _____	\$ _____	\$ _____
Auto 2 Yr/Make/Model: _____ \$ _____	\$ _____	\$ _____	\$ _____
Business & rental property Name of Properties: _____ \$ _____ Location/Address of Properties: _____ \$ _____	\$ _____	\$ _____	\$ _____



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<i>Listing of Assets² (use additional sheet if necessary)</i>	<i>Market Value</i>	<i>Outstanding Debt/Liability</i>	<i>Net Value (Market Value less Debt)</i>
Farm land and other land holdings Location of Properties _____ Location/Address of Properties: _____	\$	\$	\$
Farm and/or business equipment (including livestock and crops) Description of asset: _____	\$	\$	\$
Other Assets Description of asset: _____	\$	\$	\$

Claims or potential third party claims seeking to recover payment of all or a significant portion of the hospital account.

Description of claim: _____

¹The method of determining income shall include, but is not limited to adjusted gross income plus non-taxable retirement income (i.e., Social Security), child support, unemployment compensation and "in-kind" payments (use of property rent free). The value of food stamps will be excluded from "in-kind" payment consideration.

²The guidelines for determining assets include, but are not limited to, primary dwelling (and attached land), automobiles, liquid assets, investments, farm land, business property, rental property, farm and/or business equipment including livestock and crops. All real property will be considered at fair market value. The values of both real and personal property will be reduced by any existing liabilities incurred by the applicant in obtaining the assets (net assets) with the exception of primary dwelling. The primary dwelling net asset will be the amount of equity above \$100,000. Actual or potential third party liability to the patient, hospital or the guarantor by common law, contract, statute or otherwise shall be considered an asset and must be listed on the Hospital Financial Assistance application.

Patient/Guarantor Signature _____ Date _____

Submit Verification of Income and Financial Assistance Application within 10 Business Days

[Internal Office Use]

ATTACH SUPPORTING DOCUMENTATION

Recommending for Charity Care Adjustment _____ (Yes) _____(No)¹ Amount: \$ _____

Basis of Charity Care Determination:

Income/Asset Qualification: _____ Catastrophic Qualification: _____

¹Notification to patient and transaction posting to patient account.

[Approvals]

Hospital Collections Manager _____ Date: _____

Director Patient Accounting _____ Date: _____

Facility CFO¹ _____ Date: _____

Facility CAO¹ _____ Date: _____

VP Patient Accounting¹ _____ Date: _____

Executive Vice President/CFO¹ _____ Date: _____

¹If Applicable

File Copy (Scanned) – Business Office Patient Folder



Attachment B– Instructions for Completing the Financial Assistance Application

INSTRUCTIONS

Provide the completed and signed Financial Assistance Application, along with the supporting documentation listed below, to the Financial Counselor who has been assigned to your case. If you need assistance with this application, please contact the Business Office at 865-374-3000.

SUPPORTING DOCUMENTATION REQUIRED TO ACCOMPANY FINANCIAL ASSISTANCE APPLICATION

- If working, attach two (2) paycheck stubs from each adult member of the household who is employed.
- If any parties are self- employed, provide a copy of the most recent tax return, (Schedule C)
- If disabled or retired, provide verification of monthly Social Security benefits. (Letter from Social Security or current bank statement)
- If receiving other retirement income, need verification of monthly benefits.
- If not employed, need verification of unemployment and copy of last two (2) paycheck stubs.
- If last paycheck stubs cannot be located, provide the following regarding the last job worked: hire date, termination date and hourly wage.
- If not employed, provide status of being able to return to work.
- If not working and not drawing unemployment, provide a notarized letter from the person(s) providing help with living expenses.
- If no rent/mortgage and no listed primary dwelling, provide a notarized letter from the person(s) providing living quarters.
- If you have applied for disability, provide verification of the disability filing.
- If you have been denied disability and are appealing, provide verification of the appeal.
- If you are receiving food stamps, provide food stamp verification. Dependents must match those listed on charity application.
- Provide complete tax return for the last tax year, including all schedules and forms. (Note that persons who receive no income outside of Social Security benefits are not required to provide a tax return.) If you cannot locate your tax return, you may request a free transcript from the IRS by calling 1-800-908-9946.

TAX RETURN INFORMATION

- W-2s must match up to the entry recorded on the tax return.
- Dependents listed on the tax return must match entry listed on the front page of the charity application.
- If itemized deductions, must include a copy of Schedule A.
- On 1040 Form, if there are entries at lines 8-18, must include supporting MISC 1099s or Schedules (whichever applies).
- If patient has a Schedule E, rental property must be listed on the front page of the Financial Assistance application.
- If Schedule E indicates any income from a "P" or "S" Corporation, business tax return (Schedule K-1) must be included.
- If patient has an IRA distribution, the value of the IRA investment must be included on Financial Assistance application.
- If filing status is "married filing separately," must include copies of both returns.
- Please note that the e-file authorization form is not a tax return. We must have the official tax return, which is the 1040 form.