APPLICATION FOR FINANCIAL ASSISTANCE

To apply for financial assistance, on the bill from JELLICO COMMUNITY HOSPITAL, complete this application, sign your name, and return the application to the Financial Department within 30 days of your visit. Call the Financial Department If you need help at (423)784-1254.

PERSONAL INFORMATION

Name: (Please Print)	Name and Social Security Number of Patient (if different from person completing application):
Home Phone #:	Work Phone#:
Address:	City/State/Zip Code:
What County do you live in?	Is Address Permanent or Temporary?

HOUSEHOLD MEMBERS AND MONTHLY INCOME

Name of Household members	Relationship to Household Member	Age and Date of Birth	Gross MONTHLY Income	MONTHLY Welfare/Child Support	MONTHLY Payments, Pensions, Retirement, Social Security	Any Other Monthly Income

INCOME VERIFICATION

Please provide any of the following types of documentation to verify your income.

(This information will be used solely for the purpose of assessing eligibility for medical assistance.)

IRS Form W-2, Wage and Earnings Statement Paycheck Remittance	Bank Statement/Records
Individual Tax Return	Government Program
Social Security, Work Comp or Unemployment Comp letter	Telephone verification by employer
Physician Disability Statement	Patient deceased
	Other

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

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

MONTHLY EXPENSES

Rent/Mortgage payment		Car/Truck Payment	
Electric and/or Gas Payment		Child Care Expenses	
Telephone Cell Phone		Loans	
Cable/Satellite		Other: Water/Auto Insurance	

SIGNATURE AND SOCIAL SECURITY NUMBER:

I certify that all of the above is true and correct and that all income is reported. I understand that this information is being given for the determination of CHARITY CARE for services rendered at HUNTSVILLE MEMORIAL HOSPITAL; and that hospital officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to immediate denial.

X _____ X_____

SIGNATURE OF ADULT HOUSEHOLD MEMBER SOCIAL SECURITY NUMBER

DO NOT WRITE BELOW THIS LINE — FOR HOSPITAL USE ONLY
(Monthly income conversion: weekly x 4.33, Every 2 weeks x 2.15, Twice a Month x 2)

Yea _____

Yearly income conversion: monthly x 12)

Total Household Size: Monthly Income: Yearly Income:	
Food Stamps: Y / N	
Eligibility Determination: Approved ❑ Denied ❑ Pending ❑	
Reason for Denial: Income too much ❑ Incomplete Information❑ Other ❑	
Account This Application Applies To:	Patient:
Signature of Determining Official:	Date:
	Other:
Reason applicant did not complete application (if applicable):	
Reason verbal attestation of income necessary (if applicable)	

FINANCIAL ASSISTANCE APPROVAL WORKSHEET

Office use only

Name: _____ Patient Account Number(s): _____

Date of Birth: _____ Social Security Number _____

Gross Annual Household Income: $ _____ Charges: $ _____

Number in Household: _____ Amount Due: _____

Circle type of documentation or income verification provided:

- IRS Form W-2, Wage and Earnings Statement Paycheck Remittance
- Individual Tax Return
- Social Security, Work Comp or Unemployment Comp letter
- Government Program
- Telephone verification by employer
- Bank Statement/Records
- Physician Disability Statement
- Written Attestation (Patient signed Assistance Application verifying Total Yearly Income)
- Verbal Attestation (Patient verbally verified Total Yearly Income)
- Patient deceased

Circle appropriate answer in response to the following questions:

1. Is Total Gross Annual Income equal to or less than 200% of the Federal Poverty Guidelines?

(See Hospital Financial Assistance Eligibility Guidelines — Schedule A)

YES Approved for 100% financial assistance as Financially Indigent

NO Does not qualify for assistance as Financially Indigent. Continue to Step 2.

2. Is balance due after payment by all third party payors equal to or greater than 10% of Total Yearly Income?

YES Continue to Step 3.

NO Patient does not qualify for Financial Assistance.

3. Is Total Gross Annual Household Income equal to or less than 500% of the Federal Poverty Guidelines?

(See Hospital Financial Assistance Eligibility Discount Guidelines — Schedule B.)

YES Total Yearly Income is less than _____% of the Federal Poverty Guidelines. Approved for ____ % discount as Medically Indigent pursuant to Hospital Financial Assistance Eligibility Discount Guidelines — Schedule B

NO Continue to Step 4.

4. Is balance due after payment by all third party payors equal to or greater than 50% of Total Yearly Income?

YES Balance due is _____ % of the total yearly income. Eligible for _____% discount as Medically Indigent pursuant to Hospital Financial Assistance Eligibility Discount Guidelines — Schedule C.

NO Patient does not qualify for Financial Assistance.

I. ($ _____) X (_____ %) = $ _____ 2. ($_____) - ($ _____) = $ _____

Balance Due *% Discount* *Discount Amount* *Balance Due* *Discount Amt. Remaining Bal. Due*

_____

Employee Signature

If Discount = $1 - $2,000: Approval by: _____ or above
If Discount = $2,001 - $5,000: Approval by: _____ or above
If Discount = Above $5,000: Director of Patient Financial Services

Date: _____