Financial Assistance Application Worksheet

Date: ___________

Patient's Name: ______________________ Social Security #: _________________ DOB: _______ Guarantor #: _____________

Please provide all documentation listed below that applies , sign and return to address listed below. Documentation should include patient and spouses, if applicable. *Attach parent's information if patient is under the age of 18 and/or if the dependent is full-time student and claimed on parents tax return.

<u>Required Documentation</u> (*DO NOT send originals)

- ❑ If you are unemployed and have no income, you must provide verification of your circumstances. Verification can be provided by a written statement from your physician, pastor, or attorney on letterhead. If you have a pending Supplement or Social Security Claim, please provide a letter from Social Security or disability attorney.
- ❑ If you are employed, you will need to provide verification of the last three months gross income. Verification can be a current paycheck stub with the year to date gross income or a letter from your employer on company letterhead.
- ❑ Current complete tax return is required. If you are self-employed this includes the schedule C.
- ❑ If you are drawing Social Security, SSI, Social Security Disability, Veteran or Military Pension, you will need to provide verification of that income. Verification can be provided by supplying a copy of your most recent check, or letter from the government showing the amount you are drawing. If your minor children also receive a check, you must provide verification of their income as well.
- ❑ If you are drawing a retirement check, pension, annuity, short/long term disability, or worker's compensation, you will need to provide verification of that income. Verification can be provided by supplying a copy of your most recent check or letter from the income source.
- ❑ If you receive Food Stamps or AFDC (Aid for Dependent Children) you will need to provide verification of the assistance. Verification can be your approval letter outlining your proof of eligibility.
- ❑ If you receive child support, alimony, or receive any assistance from your children's other parent (not living in the household), you will need to provide verification of that income source. Verification can be a copy of your child's support order or divorce decree.
- ❑ If you are unemployed and drawing unemployment benefits, you will need to provide verification of the amount you receive. Verification can be unemployment benefit approval letter.
- ❑ If you are separated and/or going through a divorce you will need to provide legal proof of the separation; otherwise we will need spouse information.
- ❑ If your monthly expenses exceed your income, you will need to provide verification of how your monthly expenses are being satisfied. Verification can be letters of support from your family, friends, church, or other supporting organizations. If you are using credit cards, cash advances, or loans to satisfy your monthly expenses, you will need to provide copies of the most recent statement of those items.
- ❑ Proof of cash value of Life Insurance, Stocks, Bonds or 401K.
- ❑ List all assets such as real estate, rental income, investment equity, vehicles, boat, recreational vehicles, et.
- ❑ Provide the most recent copy of your and your spouse's complete bank statement (including all pages of checking, savings, or certificates of deposits). If the bank account has been closed, you will need to provide a letter from the bank stating the account has been closed.

If you need assistance in completing this application, please visit the Single Billing Office (address listed below) or call 423-408-7400 or 888-288-5174, Monday – Friday, 8:00 a.m. to 4:30 p.m.

Thank you,

Wellmont Health System

Mailing Address: Wellmont Health System
Single Billing Office
105 W. Stone Drive, Suite 6A
Kingsport, TN 37660

Rev. 7-26-16

Patient/Responsible Party Information

Full Name	Date of Birth	Age
Address (Physical Address)	Zip Code	County

Social Security No.	Dependents other than yourself: **Name, age & SS #:**	Married ( ) Single ( ) Separated ( ) Divorced ( )

Own your home ( ) Rent ( ) Landlord's Name	Mo. Pmt Mo. Pmt	Approximate Value $ Home Telephone No.

Checking Acct.	yes ( )	no ( )	If yes, what is the balance
Savings Acct.	yes ( )	no ( )	If yes, what is the balance

Employer (Name and Address)	Tel. #	Emp. Since	Mo. Income

Position or Occupation	Other Income	Insurance Yes ( ) No ( ) List:

Own Automobile Yes ( ) No ( )	Type	Value $$	Monthly Payment:	Loan Balance:

Spouse/Guarantor Information

Name:	Social Security No.	Insurance Yes ( ) No ( ) Type:		
Employer (Name and Address)		Tel. #	Emp Since	Mo. Income

Additional Assets

(This included additional vehicles, boat, recreational vehicles, life insurance, stocks, real estate, etc.)

Item	Value	Payment	Item	Value	Payment
1--			5--		
2--			6--		
3--			7--		
4--			8--		

Was the patient involved in an alleged accident? Yes ( ) No ( )

Was the patient covered by accident (third party liability) coverage? Yes ( ) No ( )

Gross Monthly Income

Patient		Spouse/Guarantor	
Employment	$	Employment	$
Social Security	$	Social Security	$
Disability	$	Disability	$
Unemployment	$	Unemployment	$
Child Support	$	Child Support	$
Rental Income	$	Rental Income	$
Public Assistance	$	Public Assistance	$
Alimony	$	Alimony	$
Other Income	$	Other Income	$
Total Income	**$**	**Total Income**	**$**

Monthly Expenses

Mortgage or Rent Payment	$	Auto Payment	$
Electric	$	Bank Loan	$
Water	$	Finance Co	$
Telephone/Cell	$	Credit Cards	$
Food Expense	$	Medications	$
Clothing	$	Cable TV	$
Auto Ins	$	Home Ins	$
Life/Burial Ins	$	Health Ins	$
Hospital Pmt	$	Physician Pmt	$
Other (Specify)	$	Other (Specify)	$
Other (Specify)	$	Other (Specify)	$

Total Household Income ___________________________________

Total Monthly Expenses ___________________________________

Total Income Less Expenses ________________________________

Applicant’s statement: I do hereby certify that the information on this form is correct and true to the best of my knowledge & that no pertinent items of information have been concealed or omitted from this application. I also understand that Wellmont Health System has the right to reverse its decision concerning charity discounts when discovery of information is made that indicates the patient/guarantor has or had the ability to pay for their services. I am giving Wellmont Health System permission to access my credit file and to provide my financial information to those companies contracted by Wellmont Health System for the purpose of financial or product recovery programs for which I may qualify.

Applicant _______________________________ Date ___________________

Comments:

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Determining Eligibility

Wellmont Health System will determine financial assistance eligibility based primarily on Federal Poverty Income Guidelines. Approved applications will be used for Wellmont Health System accounts **ONLY.**

Continued Collections During Your Application Process

Please note that extraordinary collection actions on your account will be suspended during the consideration of a completed charity application. You will have 30 days from the date of the financial application to provide all supporting documentation or your account will be released for billing. If the supporting documentation is not provided with the financial statement and/or there is any falsification of any portion of the application, your application will be denied. Wellmont Health System has the right to reverse its decision concerning financial assistance when information is presented that indicates the patient/guarantor has or had the ability to pay for their services and financial assistance should not have been approved.

For Office use only:

Received Date: _____________ **Approval Date:** _____________ **Denied Date:** ____________