Regional One Health

Financial Assistance Application Form

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Name of Insurance _____ Insurance/ID Number _____

Has the patient applied for :	What were the results?
Tenncare □ **Yes** □ **No**	□ **Yes** □ **No** □ **Pending**
Social Security □ **Yes** □ **No**	□ **Yes** □ **No** □ **Pending**
Disability □ **Yes** □ **No**	□ **Yes** □ **No** □ **Pending**
Victim of Crime □ **Yes** □ **No**	□ **Yes** □ **No** □ **Pending**
Workman's Comp □ **Yes** □ **No**	□ **Yes** □ **No** □ **Pending**

Will any of these charges be handled by an attorney? □ **Yes** □ **No**

Do you have Medical Insurance? □ **Yes** □ **No**

Do you have Medical Insurance /Medicare/Medicaid that pays for your medications? □ **Yes** □ **No**

PATIENT AND APPLICANT INFORMATION

Patient First Name	Patient Middle Name	Patient Last Name	
Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated ☐ Other (may specify_____)	Medical Record Number (MRN) *if known*	Patient Birth Date	Patient Social Security Number
Spouse First Name	Spouse Last Name	Spouse Birth Date	Spouse Social Security Number
Mailing Address _____ City State Zip Code			Main Contact Number ( ) _____ Email address: _____

Employment Status

☐ **Employed** (Name of Employer:) ☐ **Unemployed** (how long unemployed:)

☐ **Self Employed** ☐ **Student** ☐ **Disabled** ☐ **Retired** ☐ **Other** (_____)

FAMILY INFORMATION

List family members in your household, **including yourself.** "Family" includes people related by birth, marriage, or adoption who live together and are claimed as dependents on your most recently filed federal income tax return.

FAMILY SIZE_____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain*_____)

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INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you must submit a notarized written signed statement.

Examples of proof of income include:

- Current year tax return; or
- Year-to-date pay information from employer; or
- Food stamp letter or other third-party documentation; or
- An income statement from accountant; or
- Written, signed statements from employers or others (letter of support) stating your current financial situation and circumstances if you have no proof of income (notarized)

Monthly Income:

$_____

Spouse Monthly Income:

$_____

Did you file income tax in 20___ □ **Yes** □ **No**

Are you a veteran**?** □ **Yes** □ **No**

Do you receive food stamps? □ **Yes** □ **No**

If so, how much? $_____

PATIENT AGREEMENT

I am requesting that consideration be given to me by Regional One Health for Uncompensated Care and/or reduced cost medications. I understand that the information which I submit concerning my annual income and family size is subject to verification by Regional One Health. I also understand that if the information which I submit is determined to be false, such a determination will result in denial of services provided as uncompensated and/or reduced cost medications, and I will be liable for charges incurred. Furthermore, I am aware that this is a voluntary service by Regional One Health, and they maintain exclusive rights for approval or denial.

I affirm that the above information provided is true and correct to the best of my knowledge.

_____ _____

Signature of Person Applying Date

You may mail your completed forms or fax to:

Regional One Health
Patient Financial Services
877 Jefferson Avenue Memphis, TN 38103

or

Fax Number: 901.545.6780