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.

Has the patient applied within the last 6 months for *(optional):* Tenncare, Social Security, Disability, Victim of Crime, Worker's Comp □ **Yes** □ **No**
Will any of these charges be handled by an attorney? □ **Yes** □ **No**

Patient Last Name, First Name	Patient Address	City, State, Zip
Marital Status: *(optional)* ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated	Patient Birth Date	Patient Social Security Number *(optional)*

Employment Status: **Employed** Name of Employer: ___________________ **Unemployed** **Self-Employed** **Student** **Disabled** **Retired**

List family members in your household. *Attach additional page if needed*
FAMILY SIZE_____________

Name	Age	Relationship to Patient	Employer	Total gross monthly income (before taxes):

All adult family members' income must be disclosed. Sources of income include: Wages, Unemployment, Self-employment, Worker's compensation, Disability, SSI, Child/spousal support, Work study programs (students), Pension, Other

Examples of proof of income include:
- Current year tax return
- Year-to-date pay information from employer
- Food stamp letter
- Social Security disability letter
- Written, signed statement stating your current financial (notarized)

Monthly Income: $ _____________ Spouse Monthly Income: $______________
Do you receive food stamps? □ Yes □ No
Do you have Medical Insurance? *(optional)* □ Yes □ No

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 Hospital Representative Signature Date

Regional One Health
Patient Financial Services
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