APPLICATION FOR FINANCIAL ASSISTANCE

*** Please Use Black Ink**

Mountain States Health Alliance recognizes there can be a need for financial assistance with individuals that have limited income in paying hospital bills. Eligibility for financial assistance is based on established criteria and the information contained in this application.

The purpose of this form is to collect information that will enable us to make an appropriate and fair determination of your financial needs. Please complete each item on the application and include the supporting documentation listed on page 2. It is extremely important that you complete this application upon receipt and return it within 10 days to the address below.

Mountain States Health Alliance
ATTN: Financial Assistance
P.O. Box 2308
Johnson City, TN 37605-2308

Patient Account Number(s)

_____ _____ _____

_____ _____ _____

Patient Name *Last*	*First*	*Middle Initial*	Date of Birth

Responsible Party	Social Security Number		Home Phone

Address	City	State	Zip Code

Employer ❑ Unemployed	Work Phone	Are any of the accounts listed above due to a motor vehicle accident or any other personal injury? ❑ No ❑ Yes If yes, please provide the following info: Insurance Company / attorney / person asserted to have caused injury: _____ Policy Number: _____ Agent Name: _____ Phone Number: _____
Number in Household	Does employer offer Medical Insurance? ❑ No ❑ Yes If offered and you do not subscribe, please indicate reason:	

Dependent(s) - Name & Age	Are you on disability? ❑ No ❑ Yes - How long?_____	Are you a veteran? ❑ No ❑ Yes - Branch_____	Annual Gross Household Income

Spouse's Name	Social Security Number (spouse)	Work Phone

Employer (spouse) ❑ Unemployed	Does employer offer Medical Insurance? ❑ No ❑ Yes If offered and you do not subscribe, please indicate reason:

If you have any questions regarding this form, please contact Patient Financial Services at 423-431-1700 or Toll Free 1-877-281-5665.

Mountain States Health Alliance

APPLICATION FOR FINANCIAL ASSISTANCE

Please provide proof of all income and assets noted on this page, including items 1 - 5 (below). Your application cannot be considered without this information and will be returned to you if the information is not included with the application.

1. Current Pay Stub (Responsible party & spouse) **REQUIRED**
2. Last two complete Federal Tax Returns with profit and loss reportings **REQUIRED**
3. Checking, Savings & Health Savings Statements (one full month) **REQUIRED**
4. Copy of Food Stamp Certification letter.
5. Copy of police report if involved in motor vehicle accident.

INCOME (Monthly)

Patient	$ _____
Spouse	$ _____
Dependent(s)	$ _____
Public Assistance	$ _____
Food Stamps	$ _____
Social Security	$ _____
Unemployment	$ _____
Strike Benefits	$ _____
Worker's Compensation	$ _____
Alimony	$ _____
Child Support	$ _____
Military Allotments	$ _____
Pensions	$ _____
Income from: Rent, Certificates of Deposit, Dividends, Interest	$ _____
TOTAL:	**$ _____**

If you report zero income, you must submit signed statements from individuals providing your room and board, signed statements attesting to your unemployed status and a signed statement explaining how your daily expenses are being covered with zero income to report.

EXPENSES (Monthly)

Rent / Mortgage	$ _____
Homeowner's Insurance	$ _____
Property Tax	$ _____
Electric	$ _____
Gas / Propane	$ _____
Water	$ _____
Telephone / Cell Phone	$ _____
Food	$ _____
Car Payment	$ _____
Car Insurance	$ _____
Gasoline	$ _____
Alimony / Support	$ _____
Child Care	$ _____
Clothing	$ _____
Credit Cards (Total per month)	$ _____
Loans	$ _____
Medical Insurance	$ _____
Life Insurance	$ _____
Other	$ _____
TOTAL:	**$ _____**

ASSETS

Checking Account	$ _____
Savings Account	$ _____
Health Savings Account	$ _____
Certificates of Deposit	$ _____
IRAs	$ _____
Investments	$ _____
Stocks / Bonds	$ _____
Land / Property other than home you live in	$ _____

Vehicles	Make	Estimated Value
Auto #1	_____	$ _____
Auto #2	_____	$ _____
Motorcycle #1	_____	$ _____
Motorcycle #2	_____	$ _____
Boat	_____	$ _____
Recreational Vehicle	_____	$ _____

Please list any other information you feel would be helpful to us in determining your eligibility for assistance in paying your hospital bill. Attach additional documentation, if needed.

_____

_____

_____

I certify I have provided complete and accurate information in this application. I understand Mountain States Health Alliance may verify the financial information contained in this application in connection with the hospital's evaluation process and may run a credit history to verify the above information. I hereby authorize the hospital to contact my employer to certify the information provided and to request reports from credit reporting agencies. I understand that this information will be used to determine my eligibility for financial assistance and that falsification of information in this application will result in denial of any assistance.

I also certify that, except as disclosed in this application, no third party (such as an insurance company or person who caused injury to me) may be responsible for paying for the services provided to me.

Patient / Guardian / Guarantor Signature _____ Date _____