

Financial Assistance Application

Please return application and all requested documents to P.O. Box 249, Goodlettsville, TN 37070-0249

Please complete the application to the best of your ability, and as fully as possible. This will help us answer your request as quickly as possible. If you would like to provide additional information of any kind that you feel will help us better understand your situation, please attach a letter to this application.

You must also provide proof of gross income. This may be in the form of your last three (3) pay stubs, last year's tax return, or other records documenting your year-to-date income.

PATIENT INFORMATION (PLEASE PRINT)

Account No. _____ Patient Name: _____

Birth Date: _____ Marital Status: _____ Sex: _____ SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Email: _____

Employer: _____ Full Time Part Time Hours per week _____

Employer Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

RESPONSIBLE PARTY'S INFORMATION

Name: _____

Birth Date: _____ Marital Status: _____ Sex: _____ SS#: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Email: _____

Employer: _____ Full Time Part Time Hours per week _____

Employer Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

RESPONSIBLE PARTY SPOUSE INFORMATION

Spouse's Name: _____ SS#: _____ Birth Date: _____

Spouse's Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

DEPENDENTS

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

**Premier
Radiology**



Ascension

FINANCIAL ASSISTANCE APPLICATION

GROSS MONTHLY INCOME

Applicant Earned Income	_____
Applicant Spouse's Income	_____
Social Security Benefits	_____
Pension/Retirement Income	_____
Unemployment Compensation	_____
Worker's Compensation	_____
Interest/Dividend Income	_____
Child Support	_____
Alimony	_____
Rental Property Income	_____
Food Stamps	_____
Other	_____
Other	_____
TOTAL GROSS INCOME	\$ _____

ASSETS

Cash on Hand	_____
Savings Account	_____
Checking Account	_____
C.D.'s	_____
Securities	_____
Life Insurance	_____
Other Real Estate	_____
Other	_____
Vehicle / Make & Model	
Year	Value
_____	_____
_____	_____
_____	_____
Financial Settlements:	
Life Insurance	_____
Inheritance	_____
Other	_____
TOTAL VALUE OF ASSETS	\$ _____

MONTHLY LIVING EXPENSES

	Payment	Balance
Mortgage/Rent	_____	_____
Electricity	_____	_____
Gas	_____	_____
Telephone	_____	_____
Water	_____	_____
Groceries	_____	_____
Cable TV	_____	_____
Car Payment	_____	_____
Cell Phone	_____	_____
Day Care	_____	_____
Child Support/Alimony	_____	_____
Prescription Drugs	_____	_____
Credit Cards:		
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
Other Doctor/Hospital Bills:		
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
Insurance Expense:		
1. Automobile	_____	_____
2. Property	_____	_____
3. Medical/Life	_____	_____
Other Loan Payments:		
1. _____	_____	_____
2. _____	_____	_____
Other Monthly Payments:		
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
TOTAL MONTHLY EXPENSES	\$ _____	\$ _____

COMMENTS: _____

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

_____ Date _____ Signature of Patient, Spouse, Guarantor or Legal Representative

Financial Application Checklist

Definition of Household to count for income and household size calculations:

1. All persons within the single family unit should be counted. This is defined as husband, wife and children.
2. All children 21 and older will not be included in the household size unless the child is in school full-time up to the age of 25.
3. Parents living in the home with their adult child will not count toward the household size or income of that child.
4. Common Law marriages will count toward income and household size.
5. Spouses who are separated will not count toward income and household size.
6. Significant Others will not count toward income and household size unless they have been living together for 6 months or longer.
7. Any persons that the patient is legally responsible for will count toward household size.
8. Grandparents taking care of grandchildren in the home where the parent is not in the home will count toward income and household size.
9. International Visitors - Applications will include the household income of the sponsor.

In order to process your application in a timely manner, please ensure all information is included and returned within 15 days.

Previous year's tax return (20_____) showing gross amount of income and all dependents included on that tax return.

• **Copies of last 3 check stubs, including spouse's, if applicable. If social security, disability, retirement or unemployment benefits are included in monthly income, please enclose proof as well. APPLICATIONS WILL BE DENIED IF THIS IS NOT PROVIDED.**

Copies of all current bills. (Utilities, rent/mortgage, medical/hospital bills, etc.)

If you are not working and you rely on someone else for food and housing, a letter from that provider (enclosed Letter of Support) must be completed and notarized.

If you receive food stamps you will need to provide proof documenting the amount you receive.

Should you have any questions in regards to completing this application please contact:

[Rhonda Lee at 615.851.6033 ext: 2051](tel:615.851.6033)

Please understand that incomplete applications, lack of returned information, or if the application is not returned within 15 days, this will cause the application to be denied.

Please return the application and all requested documents to address listed below:

PhyData

PO Box 249

Goodlettsville, TN 37070