Southwestern Medical Center

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Instructions:

As part of our commitment to serve the community, Southwestern Medical Center elects to provide financial assistance to individuals who meet certain financial requirements.

To determine if you may qualify for financial assistance, you will need to complete the attached Financial Assistance application and provide the required documentation. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please provide the information requested by Fax: 866-908-8875 or mail to the following address:

Attn: Financial Assistance Dept
552 Metroplex Drive
Nashville, TN 37211

Income Verification:

IN ORDER TO CONSIDER YOUR REQUEST FOR FINANCIAL ASSISTANCE, VERIFICATION OF INCOME IS REQUIRED. PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS:

- Governmental Assistance, Social Security, Workers Compensation or Unemployment Compensation Determination Letter
- Income Tax return for previous year

PLEASE ALSO INCLUDE ALL OF THE FOLLOWING THAT APPLY TO YOU/YOUR SITUATION:

- IRS Form W-2, Wage and Earnings Statement for all household earnings
- Last 2 paycheck stubs for all household earnings
- If not currently working, please provide proof of your unemployment. If you are not currently receiving unemployment benefits, please include a statement as to how you are taking care of your financial responsibilities without income. If someone is assisting you, please provide statement from this individual as well.
- Written documentation from other income sources (i.e. child support, alimony, other)
- Bank Statement that contains income information

In the event income verification is unavailable, please contact our office for further instructions. Applications without verification are considered incomplete and **WILL NOT BE PROCESSED.** Please return the application and verification of income within 10 days to the above address. If this documentation is not received **within 10 days** after your discharge date, your Financial Assistance application **will not** be processed and the account will resume our normal collection process.

Notification of Determination:

We will notify you of your eligibility following receipt and review of all necessary information. The notification will be mailed to the mailing address you have provided on the Financial Assistance Application.

Physician Services:

The physicians and other ancillary providers that offer services at Southwestern Medical Center are not employees of Southwestern Medical Center. You will receive separate bills from your private physician and from other physicians whose services you required (pathologist, radiologist, surgeon, etc.) The Financial Assistance Application *will not* apply to any amounts due by you for physician services. For questions regarding their bills, or to make payment arrangements for physician services, please contact the individual physician's office.

For assistance in completing this application, please contact Customer Service at 1-800-433-1009 Monday through Friday between the hours of 8:00 am and 5:00 pm (Central time).

Southwestern Medical Center

FINANCIAL ASSISTANCE APPLICATION

FINANCIAL ASSESSMENT DETERMINATION

PATIENT INFORMATION/INFORMACION DEL PACIENTE			
Patient Name/Nombre del Paciente	Account Balance/Balancia de Cuenta	Patient Number/Numero del Paciente	Date of Birth/Fetch del Nacimiento
Admission Date?Fecha de Entrada	Discharge Date/Fecha de Despedida	Social Security #/Num de Seguro Social	Marital Status/Estado Civil
Home Address/Direccion de Residencia			
City/Ciudad		State/Estado	Zip
Name of Medical Provider/Nombre Del Proveedor De sercisios Medicos		Beginning Coverage Date/Fecha del Comienzo	
Name of Doctor/Nombre del Medico			
Employer Name/Nombre		Occupation/Ocupacion	Telephone/Telefono

GUARANTOR INFORMATION/PERSONA RESPONSABLE			
Name/Nombre		Social Security #/Num de Seguro Social	Age/Edad
Relationship to Applicant / Relacion con el Paciente	Address/Direccion		Telephone/Telefono
City/Ciudad		State/Estado	Zip
Employer Name/Nombre		Occupation/Ocupacion	Telephone/Telefono
Employer Address/Direccion			
City/Ciudad		State/Estado	Zip

FINANCIAL INFORMATION/INFORMACION FINANCIAL			
Total Monthly Income/Ingresos Mensuales	# of Dependents/Cuantos Dependientes	Residence: ❑ Rent ❑ Own Casa: ❑ Renta ❑ Propia	Car (Model/Year)/ Car (Modelo/Ano)
OTHER INCOME		**GUARANTOR/RESPONSIBLE PARTY**	**SPOUSE**
Social Security			
Pension			
Unemployment			
Worker's Compensation			
VA Benefits			
Rental Income			
Stocks, Bonds, 401K			
Dividend/Interest			
Child Support			
Alimony			
Other			

RESOURCES/RECURSOS

Southwestern Medical Center

Name of Bank/Nombre del Banco	Checking Account/Cueta de Cheques	Savings Account/Cuentas de Ahoras
	$	$

MONTHLY EXPENSES/GASTOS MENSUALES

Rent/Mortgage/Payment Payment/Renta o Pago Hipotecario $	Water bill/Pago de Agua $	Gas Bill/Pago de Gas $	Phone Bill/Cuenta de Telefono $
Electric Bill/Pago de Electricidad $	Car Payment/Pago de Carro $	Insurance Premium/Pago de Prima $	Other Bills/Otro Gastos $

HOUSEHOLD COMPOSITION/INFORMACION DE LA CASA

Name/Nombre	Relationship/Relacion con el Paciente	Date of Birth/Feche de Nacimiento	Social Security #/Num de Seguro Social

If unable to provide the requested documents, please explain below/Por favor de dar una explicacion si no es possible proveer los documentos:

COMMENTS/COMETARIOS :

AFFIDAVIT/DECLARACION JURADA

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.

I agree to tell the provider of service within ten (10) days if there are any changes in my (or the person on whose behalf I am acting) income, property, expenses or in the persons household or any change of address.

I understand that I may be asked to prove my statements and my eligibility statements will be subject to verification by contact with my employer, bank credit verification and property searches.

I understand the county is required by law to keep any information I provide confidential.

I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county from the proceeds of litigation or settlement resulting from such an act.

Delcaro bajo pena de perjuria que las respuestas que he dado son verdaderas y correctas al major de mi conocimiento.

Acuerdo decirle al abastecedor del servicio en el plazo de diez dias si hay algunos cambios en mi (o personas en elfavor que yo este actuando) renta, propiedad, gastos o en las casa de las personas o cualquier cambio de direccion.

Entiendo que puedo ser pedido probar mis declaraciones de la elegibilidad estaran conforme a la verificacion al lado de contacto con mi patron, verification del credito de banco y busquedas de propiedad.

Entiendo que el condado es requerido por ley de protejer cualquier informacion que yo proporcione confidencial.

Tambien convengo, en la consideracion de recibir servios del cuidado medico como resultado de un accidente o lesion, de tener que reembolsarle al condado de los ingresos de la demanda o cualquier resultado de tal acto.

_____ _____

Signature/Firma Date/Fecha

For Hospital Use Only/Uso Solamente Para el Hospital

Facility:	❑ Accepted	❑ Denied
COMMENTS:		
_____ Signature Approval	_____ Date	