Catholic Health Initiatives
Memorial Health Care System
Financial Assistance Application Form (Page 1 of 4)

Please note - _____ may access external validation resources to assist in determining whether a full application for assistance is required.

Financial Assistance Application

1) Patient Name	**Social Security #**	**Date of Birth**	**Account #**
2) Guarantor's Name	**Relationship to Patient**	**Date of Birth**	**Social Security #**
3) Guarantor's Address	**County of Residence**	**Home Phone #**	**Length of Residence**
3) City	**State**	**Zip Code**	
4) Previous Address (if less than 2 years at above)	**City, State, Zip**	**Marital Status**	**# of Dependents in Household**

5) Have you applied for Medicaid or any other State/County Assistance? (check one)	**Yes**	**No**
Application Date	**Caseworker Name/Telephone Number/Status of Application**	

If the answer to #5 is Yes, please do not continue to complete any additional sections of the form. Please contact a financial counselor for additional information at _____

6) List Names and Ages of Dependents in Household:

7) Employer (Guarantor/Patient)	**8) Previous Employer (Guarantor/Patient)**	**9) Spouse Employer**
Address	**Address**	**Address**
Job Title/Length of Employment	**Job Title/Length of Employment**	**Job Title/Length of Employment**
Business Telephone #	**Business Telephone #**	**Business Telephone #**
Hourly Rate	**Hourly Rate**	**Hourly Rate**
Monthly Income Gross	**Monthly Income Gross**	**Monthly Income Gross**
Monthly Income Net	**Monthly Income Net**	**Monthly Income Net**
10) Other Income Source/Amount	**Total Family Monthly Income**	**Total Family Income last 12 months**

11) Other Assets (Stocks Bonds, Property, Boat, Business, etc.)

12) Have you filed Bankruptcy? Yes No	**Chapter 7**	**Chapter 13**	**Date Filed**	**Date of Discharge**
13) Are you a Homeowner? Yes No	**Approximate $ Value**	**Approximate Balance on Loan**		**Years left on Loan**
14) Bank Name – Checking Account	**Avg. Checking Balance**	**Bank Name - Savings Account**		**Avg. Savings Balance**

Catholic Health Initiatives
Memorial Health Care System
Financial Assistance Application Form (Page 2 of 4)

15) AUTOMOBILE(S) 1. Make:	Model:	Year:	Pymt Amount:	Balance Due:
2. Make:	Model:	Year:	Pymt Amount:	Balance Due:
3. Make:	Model:	Year:	Pymt Amount:	Balance Due:
4. Make:	Model:	Year:	Pymt Amount:	Balance Due:

Monthly Expenses:

Description	Monthly Payment	Payment To	Balance Due	Limit
Rent/Mortgage	$		$	$
Charge Cards	$		$	$
	$		$	$
	$		$	$
	$		$	$
	$		$	$
	$		$	$
	$		$	$
Bank Loans	$		$	$
	$		$	$
	$		$	$
	$		$	$
School Loans	$		$	$

List Other Expenses Below:

	Monthly Payment		Monthly Payment		Monthly Payment
FOOD	$	MEDICATION	$	AUTO INS	$
UTILITIES	$	LIFE INSURANCE	$	OTHER	$
GAS (CAR)	$	MEDICAL BILLS	$	OTHER	$
TOTAL MONTHLY EXPENSE	$				

Note: Attach additional sheet if necessary. Important: income verification must be attached – W2, Pay Stub, Tax Return with schedules, etc.

PLEASE READ THE FOLLOWING BEFORE SIGNING AND DATING THE APPLICATION

Please be advised that your signature indicates you have agreed to attach all income verification. In addition to the items requested by this application, you may attach bank statements, copies of social security checks (or letters). If there is no income, please verify how expenses are being met. It is important to explain a lack of income completely so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach the last 2-3 months of bank statements. Additional information may be requested by the financial counselor. All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.

CERTIFICATION

1. **I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.**
2. **I will apply for any and all assistance that may be available to help pay this bill.**
3. **I understand the information submitted is subject to verification; therefore, I grant permission and authorize any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of _____ information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize _____ to perform a credit check for both guarantor/patient and spouse.**

Signature (Guarantor/Patient)	Date
Signature (Spouse)	Date

Please complete and mail your Financial Assistance Application to: Attn: Business Office - Financial Assistance Request, Memorial Health Care System, 2525 de Sales Avenue, Chattanooga, TN 37404

Catholic Health Initiatives
Memorial Health Care System
Financial Assistance Application Form (Page 3 of 4)

DIRECTIONS FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

1: Complete the patient name, patient's social security number, patient's date of birth, and the hospital account number(s) if known.

2: Complete the guarantor name, relationship to patient, guarantor's date of birth, and guarantor's social security number. If the guarantor is the same as the patient, note "Same" in this field.

3: Complete the guarantor's address, home telephone number and length of residence at this address.

4: Complete the guarantor's previous address (if current residence is less than two years), guarantor's marital status, and number of dependents living in household. If there are no dependents, please mark "-0-" in the dependent field.

5: Complete the questions regarding Medicaid and other State/County assistance. Please advise if you have applied for assistance (and on what date). Provide the assigned Caseworker's name, telephone number and the status of the application. You may attach a separate sheet if needed. If your response is "Yes", please do not proceed to complete any additional sections of the form. Please contact a financial counselor for additional information. If this section does not apply to you, please indicate this by marking it with N/A.

6: List the names and ages of dependents.

7: Complete the employer information for the guarantor or patient, depending upon who has responsibility for the balance. Please complete the name of the employer, the employer's address, the guarantor/patient's job title and length of employment. Please also include the guarantor/patient's business telephone number, hourly (or salary) rate, and the monthly income (both gross and net). If there is no employment, please note how expenses are being met.

8: Complete the previous employer information for the guarantor/patient. This includes the employer's name and address, the guarantor/patient's job title and length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If there is no prior employment, mark "N/A".

9: Complete the income information for the guarantor/patient's spouse. Include the name of the employer, the employer's address, job title/length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If the spouse is unemployed, or there is no spouse, mark "N/A".

10: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This also includes rental income, alimony, pension income, welfare and VA benefits. Complete the total family income (add the guarantor/patient net income), then complete the total family income from the last 12 months. If there has been no income, please note how expenses are being met.

11: Please complete the section listing other assets you may have. This includes stocks, bonds, property, boats and businesses you may own. Use additional paper if needed to give complete details. If there are no additional assets, please mark "N/A".

12: Please indicate if you have ever filed bankruptcy. If you have not filed bankruptcy, please mark "No". Please verify that all questions have been completed. Attach additional paper if needed for any explanations.

13: Please complete the homeowner information. If you are a homeowner, please note the approximate dollar value, the approximate balance on the loan, and the number of years left on the loan. If you are not a homeowner, please mark "No".

14: Please complete the banking information as requested and list the bank name. Complete the checking account number and provide the average checking account balance. Please do the same for the savings account field. If there is no savings account, please place "N/A" in the savings field.

15: For automobile information, please list the make, model and year of your vehicle. Please list the monthly payment amount and the current balance. Attach additional documentation for more than four autos.

Catholic Health Initiatives
Memorial Health Care System
Financial Assistance Application Form (Page 4 of 4)

HOW TO COMPLETE THE MONTHLY EXPENSE SECTION (copies of monthly bills/statements may be requested)**:**

RENT/MORTGAGE: Please verify the amount you are paying in rent or by mortgage. Indicate to whom the payment is made, the account number and the current balance due. If you do not pay rent or mortgage, please note why you have no payment or if you live with relatives or others. Use additional paper if needed.

CHARGE CARDS: Please indicate any charge card payments you are currently making. Please indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Please indicate the credit limit for each card. Use additional paper if you needed to complete this field. If you have no charge cards please note "N/A".

BANK LOANS: Please indicate any bank loans you may be paying. Indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Use additional paper if needed to completely explain this field. If you have no bank loans, please mark "N/A".

SCHOOL LOANS: Please list any educational loans you may be paying. This can include, but not be limited to, college loans, private school loans (or tuition), day-care expenses or any other loans that apply to education. Please use additional paper if needed. Please specify if you are paying school loans, etc. If this does not apply to you, please mark "N/A".

LIST OTHER MONTHLY EXPENSES:

FOOD: Please list the amount paid for food on a monthly basis.

UTILITIES: Please list the amount paid on a monthly basis for electricity, gas, water, trash and any other utility you may pay. Please add these and place the total (for all of them) in the utilities section. If there are no monthly utilities paid, please mark "N/A" in this section and explain. Use a separate sheet of paper if needed.

GAS (CAR): Please list the amount paid on a monthly basis for transportation needs related to your vehicle. If there is no payment made on a monthly basis for gas, please mark the field "N/A".

MEDICATION: Please add the amounts you pay on a monthly basis for medication needs. If there are several prescriptions or medications you take, please add them together and place the total amount in this section. If there are no monthly medication payments, please place "NA" in this section.

LIFE INSURANCE: If you have a life insurance policy, please indicate the monthly amount you pay. If there is no payment, please place "N/A" in this section.

MEDICAL BILLS: Please add any medical bills you may be paying on a monthly basis. This may include, but not be limited to, physician bills, insurance co-pays, insurance deductibles, other hospital bills, radiology bills, ambulance bills, etc. Please use a separate sheet of paper to list these amounts. Add them together and place the total amount paid on a monthly basis for these accounts in this section. If there are no monthly medical payments being made, please place "N/A" in this section.

AUTO INSURANCE: Please place the total amount you pay on a monthly basis for auto insurance. If you pay on a quarterly basis, please divide the quarterly payment by three and place the amount in this section. If you pay every six months, please divide the total amount you pay by six and place the amount in this section. If there is no monthly payment being made, please mark N/A in this section.

OTHER: This includes any monthly payments you currently are making that are not listed in the previous sections. Please provide details of what you are paying, to whom, and the balances due. Please use a separate sheet of paper if needed. If this section does not apply to you, mark "N/A".

TOTAL MONTHLY EXPENSES: Please estimate your monthly expenses and place this amount in this section.