CUMBERLAND MEDICAL CENTER
"Quality Care Delivered By Quality Professionals"

Financial Assistance Application

Guarantor Information

Name: _____ SS #: _____ Date of Birth: _____

Address: _____

Phone # (Home): _____ (Work): _____ (Cell): _____

Employed: yes _____ no _____ If no, please indicate how long unemployed: _____

Employer name: _____ Occupation: _____

How long employed: _____

Are you disabled? yes _____ no _____ Are you receiving disability benefits? yes _____ no _____

Do you have health insurance? yes _____ no _____ If yes, please indicate type: _____

If not, please indicate why you do not currently have insurance: _____

Spouse Information

Name: _____ SS #: _____ Date of Birth: _____

Address: _____

Phone # (Home): _____ (Work): _____ (Cell): _____

Employed: yes _____ no _____ If no, please indicate how long unemployed: _____

Employer name: _____ Occupation: _____

How long employed: _____

Are you disabled? yes _____ no _____ Are you receiving disability benefits? yes _____ no _____

Do you have health insurance? yes _____ no _____ If yes, please indicate type: _____

If not, please indicate why you do not currently have insurance: _____

Dependent Information

Name	Age	Name	Age
_____	____	_____	____
_____	____	_____	____
_____	____	_____	____

Monthly Income

Guarantor: $_____ Spouse: $_____ Dependent(s): $_____

Other: $_____ $_____

Bank Name & Address: _____

Checking Account Number: _____ Balance: $_____

Savings Account Number: _____ Balance: $_____

Monthly Expenses

Do you own or rent your home? own _____ rent _____ Rent/Mortgage Payment: $_____

Electricity: $_____ Water: $_____ Natural Gas: $_____

Cable TV: $_____ Phone (land line): $_____ (cellular): $_____

Internet Service: $_____ Groceries: $_____ Medications: $_____

Automobile Payment(s): $_____ Gas & Maintenance: $_____

Please list other monthly bills that have not been listed above, such as medical bills, credit cards, etc.

Type of Bill	Balance	Monthly Payment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please use the following space to indicate any special circumstances that we may need to know to process your application. Also indicate how you are meeting your financial obligations if no income.

_____

_____

_____

_____

***IMPORTANT NOTE**: Copies of most recent W-2(s), tax return(s), paycheck stub(s), bank statement(s), utility bills, TennCare denial letter and any other documents necessary to verify income must be attached to this application before consideration will be given.*

Account Information

Patient Name	Account Number	Admit Date	Discharge Date	Balance
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Total $_____

Note: If more than three accounts are owed to CMC, please attach a computer printout of accounts. (This can be provided by the Patient Accounts representative that gave you this application.)

I hereby request Cumberland Medical Center make a written determination of my eligibility for financial assistance. I understand that the information that I have submitted on this application is subject to verification by CMC. I also understand that if the information I submit is determined to be false, such determination will result in a denial of providing financial assistance and I will be liable for all charges incurred. This request only covers the specific dates of service listed on this application. This determination is based upon the income reported and covers only hospital charges. This determination is in no way considered to extend to any professional fees outside this facility.

_____ _____

Signature of Guarantor *Date Signed*

REMAINING SPACE IS FOR HOSPITAL USE ONLY

_____ _____

Hospital Representative Date Received

_____ _____ _____

Approval at 100% Approval at 50% Denial

If denied, reason(s): _____

_____

_____ _____

Committee Chair Date

Financial Assistance Application Checklist

Along with this completed application, copies of the following items (most recent--for both the guarantor and spouse) must be turned in to CMC for consideration of Financial Assistance:

- □ **1) W-2**
- □ **2) Tax Return**
- □ **3) Paycheck Stub**
- □ **4) Any other information necessary to verify income**
- □ **5) Bank Statement(s)**
- □ **6) Utility Bills**
- □ **7) Documentation of other Monthly Expenses (mortgage or rent, car payments, insurance premiums, etc.)**
- □ **8) TennCare Denial Letter**

Without copies of this information, your Application for Financial Assistance will not be processed. You should submit only copies (no originals). Any information submitted will not be returned to the applicant.

Please complete this application and submit it with all required documents as soon as possible. If you have any questions, please call the Patient Accounts Department at Cumberland Medical Center at (931) 459-7281.