**PLACE PATIENT LABEL HERE OR PROVIDE BILLING NUMBER(s) :**

_____

_____ **and MRN** _____

**Return To:**

**Methodist Le Bonheur Healthcare - Self Pay Department**

P O Box 172193
Memphis, TN 38187-2193
Attn: Financial Assistance Program
Telephone: (901) 842-1255 Fax: (901) 266-6474
Email: PatientFinAssist@mlh.org

# APPLICATION FOR FINANCIAL ASSISTANCE

## Patient

Name: _____

Address: _____

City: _____ State:____Zip: _____

S.S. # _____ Employer: _____

Primary Phone: _____ Cell Phone: _____

Email Address: _____

## Responsible Party (R.P.)

**Same As Patient?** Yes? ◯ No? ◯

**If No, Please Complete** R.P. Name: _____

R.P. SS#: _____

R.P. Employer: _____

***List all Members of your household/if employed give employer's name if more space is needed please use back of the form***

| Name | Age | Relationship | Employer | Your Legal Dependent? |
|---|---|---|---|---|
| | | | | Yes? ◯ No? ◯ |
| | | | | Yes? ◯ No? ◯ |
| | | | | Yes? ◯ No? ◯ |
| | | | | Yes? ◯ No? ◯ |
| | | | | Yes? ◯ No? ◯ |

***TOTAL HOUSEHOLD MONTHLY GROSS INCOME:*** **$** _____

Please provide proof of income along with your financial application. Examples accepted are, copy of current 1040 tax return, (contact IRS at 800-908-9946 or 800-829-0922) if you do not file taxes please provide at least one of the following documents:

- Social Security benefits letter
- Social Security disability letter
- Welfare or Temporary Assistance for Needy Family letter
- Food Stamp letter
- Unemployment letter/check displaying name and date.

**1)** Are you, your spouse or any of your dependents presently covered under any health insurance program? **Yes?** ◯ **No** ◯

**2)** Have you had insurance coverage within the last 6 months? **Yes?** ◯ **No?** ◯

- If yes, please provide name of insurance: _____
- If employer sponsored, please provide name ofemployer: _____

**3)** If you or your spouse are employed, does the employer offer health care insurance? **Yes?** ◯ **No?** ◯

**4)** Have you applied within the last 6 months for Tenncare, Medicaid, Social Security Benefits, Disability Benefits, Victims of crime, or any third party liability claims? **Yes?** ◯ **No?** ◯

THE FOLLOWING DISCLAIMER SHOULD BE READ BY PATIENT OR RESPONSIBLE PARTY BEFORE SIGNING FORM.

I am requesting consideration for medical financial assistance. I understand that the information that I submit is subject to verification which may include an inquiry of my credit history. I also understand that if the information that I submit is determined to be false, such a determination will result in denial for consideration. I am aware that this is a voluntary service by Methodist Le Bonheur Healthcare and they maintain exclusive rights for approval or denial. I affirm that the information provided is true and correct to the best of my knowledge.

_____ _____

**Applicant's Signature** **Date**

_____ _____

**Hospital Representative's Signature** **Date**