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) 542-5347 Fax: (901) 266-6474

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 be prepared to provide proof of income. Examples accepted are: Prior year 1040 tax return, Social Security Administration statement of benefits, award letter for disability and/or retirement, food stamp approval letter, approval for unemployment benefits, or other proof of government assistance.
Please be prepared to provide proof of legal residency. Examples accepted are: United States work visa, property tax statement, rental agreement, driver's license or utility bill.

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 of employer: ____________________

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**

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