PRISMA HEALTH®

Patient Information if under the age of 18		
Patient Name *(Last, First, Middle)*	Social Security Number	Date of Birth *(MM, DD, YYYY)*

Guarantor or Responsible Party			
Name *(Last, First, Middle)*	Social Security Number	Date of Birth *(MM, DD, YYYY)*	
Address	City	State, Zip Code	Phone
Household Size *(Patient, Spouse and Dependents)*	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced		
Employment Status: ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Unemployed ☐ Student ☐ Disabled		If unemployed, last worked date: _____/_____/_____	
Employer Name		Gross Income (Before Taxes) $_____ ☐ Weekly ☐ Biweekly ☐ Monthly	

- ***Please provide two most recent paycheck stubs to support household income.***
- ***If there is any income on this application related to self-employment, we must have recent income taxes.***

Household Members as claimed on tax return *(use separate page for additional dependents)*

Relationship	**Name** ***(Last, First, Middle)***	**Date of Birth** ***(MM, DD, YYYY)***	**Income** ***(If applicable)***
Spouse/Life Partner			Gross Income (Before Taxes) $_____ ☐ Weekly ☐ Biweekly ☐ Monthly
Child			
Child			
Child			
Child			

Other Sources of Income (Not Listed Above)

Income Description	**Monthly Income Amount**
Interests/Dividends/Investments	$ _____
Unemployment/Workers' Compensation	$ _____
Pension/Retirement/Social Security	$ _____
Property Income	$ _____

Please provide supporting documentation for income listed above

Bank Account(s) *(Example: Stocks, Bonds, Savings, Other Investments)*

Source	**Balance**
Checking Account	$ _____
Savings Account	$ _____
Money Market Account	$ _____
Other	$ _____

☐ **I do not have a checking, savings, or money market account**

Coverage Information

PRISMA HEALTH

I have a: ☐ Lawsuit ☐ Settlement ☐ Personal Injury Claim ☐ Liability Claim

☐ Workers' Compensation Claim ☐ None

Attorney/Firm Name: _____

I have insurance available through: ☐ None ☐ My Employer ☐ Spouse's Employer ☐ Cobra ☐ Parents

☐ Health Share Ministry Plan ☐ Other

Insurance Company Name: _____

Have you or a family member, in your household, applied for Medicaid within the last three months?

☐ No ☐ Yes Date applied: _____

Have you applied for Social Security Disability: ☐ Yes ☐ No

If yes, what is the status of your application: ☐ Denied ☐ Appeal ☐ Attorney Level ☐ Pending ☐ Approved

If recently awarded, attach the current Social Security Award Letter or Disability award letter for spouse and any children.

Please note, failure to complete all sections of this form may result in a denied application.

Attestation

I understand that this application applies only to services provided by Prisma Health. This does not apply to services provided by others who may have assisted with my care. I understand that not all medical services at Prisma Health qualify for financial assistance.

Prisma Health reserves the right to reverse financial assistance approval and pursue alternate reimbursement or collections as a result of newly discovered information, including insurance coverage, payment to the applicant, or pursuit by applicant of a personal injury claim related to the services received or requested. All payments received by Prisma Health after financial assistance is awarded will result in the reversal of the adjusted amounts to resolve the remaining self-pay balance without creating a balance due or a credit balance.

I hereby certify that the information in this application is true and correct to the best of my knowledge. I understand that providing incorrect information may result in this application being denied. Should the information provided on this application be determined at any time to be incorrect, the financial assistance provided to me by Prisma Health may be revoked and I will be responsible for the original account balance. I further understand that if any information I provided should change, I will promptly notify Prisma Health.

Patient/Responsible Party Signature	**Printed Name**	**Date**

Return Applications		
By Mail: Blount Memorial Hospital Financial Assistance 907 E. Lamar Alexander Pkwy. Maryville, TN 37804	**By Fax:** (865) 977-4605	**By Email:** bmhbusinessoffice@prismahealth.org