

This financial assistance application packet includes a summary of our assistance program, the application (confidential financial evaluation), and a checklist of supporting documentation required to complete your application.

Your application for financial assistance is not a guarantee of approval. We will notify you of our decision as soon as possible after we receive your completed application and support documents. We are usually able to make a decision within 30 days. While we are reviewing the completed application and supporting documents you give us, you will not receive bills or phone calls for any balances covered by this application. After your application and supporting documents are turned in and under review, you will not receive bills or phone calls for any balances covered by this application. If assistance is not approved, you will owe those amounts.

Bills for services provided to you by physicians not employed by—or any facility not owned by—Blount Memorial are not covered by this application, even if these services were provided to you as part of the care you received from Blount Memorial. If you have questions about services billed by other providers, such as radiologists, anesthesiologists, and pathologists, please contact them directly.

If you have any questions or need assistance completing your application, please contact the Business Office at 865.977.5522 or business office@bmnet.com.

Para la versión en español, haga clic aquí. Versión en español



Financial Assistance Application Checklist

- 1. Complete the attached Confidential Financial Evaluation. <u>Your signature and the signature of your spouse or a witness are required.</u>
- 2. Include copies of all the following documentation that applies to you, and return this checklist:

Included	Doesn't	
	apply	
[]	[]	
		Copy of last year's income tax form IRS 1040 filed for your household. If you didn't file a return, please explain why:
[]	[]	If you are self-employed include all the following:
[]	[]	Schedule A – Itemized Deductions
[]	[]	Schedule C – Profit or Loss from Business
[]	[]	Schedule 1 – Additional Income and Adjustments to Income
[]	[]	Copy of the Quarterly IRS 1040 forms reporting year-to-date net profit or loss, or written, notarized statement from your company accountant listing the business year-to-date gross income and expenses
[]	[]	If you have <u>investments</u> , include a copy of the completed <u>Schedule B – Interest and Ordinary Dividends</u>
[]	[]	Copy of savings statement for current value of retirement (401K, TSA, etc.) or other savings plan
[]	[]	Copy of the most recent bank statement (dated within last 45 days)
[]	[]	Copy of mortgage statement with current balance due Verification of current income (send all of the following that apply to you and your spouse):
[]	[]	Copy of the most recent pay stub showing year-to-date earnings for you and your spouse .
[]	[]	Copy of Separation Notice from employer or unemployment pay stubs
[]	[]	Copy of food stamp eligibility letter and housing assistance approval letter (or other state assistance that applies).
[]	[]	Copy of VA benefits, disability
[]	[]	If you have applied for Social Security benefits, a copy of <u>Application</u> Summary for Supplemental Security Income (include all pages)
[]	[]	If you are unemployed, a written, notarized statement concerning your current income status from a resident relative or parent (<i>This is required if you have no household income.</i>)

3. Mail, fax, or deliver your application to: Blount Memorial Hospital

Attention: Business Office 907 E. Lamar Alexander Pkwy

Maryville, TN 37804 Fax: 865.977.4605

Our office hours are Monday through Friday 8:00 am to 4:30 pm.



Web Version

Confidential Financial Evaluation

Last Name		First		/Iiddle Initia		
Date of Birth	Social Security #		_ Telephone	#:		
Address:		City	State	_ How long Zip C		
List Spouse and Child Last Name	ren living in household: First Name	Date of Birth	Social S Nun			ly SSI/SSD e Received for Person
• 1	or financial assistance at Bl e you considering a lawsui					
Employer	Date	e of Hire	Telepho	one #		
Hourly Wage	Hours worked per we	eek Mo	onthly Incom	e		_
Spouse Employer	Date	e of Hire	Telepho	one#		
Hourly Wage	Hours worked per we	eek Mo	onthly Incom	e		_
f vou are self employed	l, please complete the follo	owing:				
a you are sen employed						
Self Employmen Name of Person		usiness or Profession Product or Services		otal Receip or Sales	ts	Average Monthly Pr
Self Employmen Name of Person		Product or Service	e	or Sales		
Self Employmen Name of Person Copy of Quarterly IRS	including	s year Schedule C	Profit or Lo	or Sales		
Self Employmen Name of Person Copy of Quarterly IRS Are you an adult living	including 8 1040 forms and previou	s year Schedule C	Profit or Lo	or Sales	siness m	ıst be provided
Self Employmen Name of Person Copy of Quarterly IRS Are you an adult living value of the company of the compa	including 5 1040 forms and previou with your parent/guardia	s year Schedule C an or family memb	Profit or Lo	or Sales oss from Buse please prov	siness mu	ist be provided
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Self Employmen Name of Person Copy of Quarterly IRS Are you an adult living y Does your parent/guard Father's Hourly Wage Mother's Hourly Wage her Income (please prov	including 8 1040 forms and previou with your parent/guardia lian claim you as an IRS of the Hours wo Hours wo vide monthly amount recei SSI / SSD \$	s year Schedule C an or family memb dependent? orked per week rked per week ved from any of the	Profit or Lo er?	or Sales oss from Bus please prov nnual Incom	siness mu	ollowing:



ASSETS

Please provide an estimated balance for the following:

Regular Checking	Regular Savings	Stocks /	/ Bonds	Money Market
\$	\$	\$		\$
CDs	HSA / HRA / FLEX Spending		401K / IRA / TSA / Retirement Savings	
	Acct			
\$	\$	\$		

Property and Equipment (a copy of your Mortgage Statement is required)	Property Assessment Value	Outstanding Debt/Liability	Net Value (Market Value less Debt)
Primary Residence (Own or Purchasing) Number of Acres	\$	\$	\$
Other Property / Business / Rental Name of Properties Location/Address:	\$	\$	\$

Monthly Household Expense	Amount	Balance Overdue	Other Monthly Expense (Name and type of debt)	Amount	Balance Owed
Rent Payment			Utilities		
Food			Cell Phone / Other		
Automobile			Motor vehicle Insurance		
Credit Cards / Other			(do not include Blount Memorial) Medical Bills		
Total:			Total:		

To the best of my knowledge the following information is factual. I acknowledge that in accordance with Statue 817.50, I understand that providing false information to defraud a hospital for purposes of obtaining goods or services is a misdemeanor in the second degree. I hereby authorize Blount Memorial Hospital to verify any of the above information.

Patient/Guarantor Signature	Date
Spouse or Witness Signature	Date
Signature of Witness	Date

Submit Verification of Income and Assets with this application within 14 Business Days