Blount Memorial Hospital

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

Revised 2/2021

Web Version

Blount Memorial Hospital

Financial Assistance Application Checklist

1. Complete the attached Confidential Financial Evaluation. Your signature and the signature of your spouse or a witness are required.
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 investments,** include a copy of the completed Schedule B – *Interest and Ordinary Dividends*
☐	☐	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 Application 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 ***(This is required if you have no household income.)***

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.

Blount Memorial Hospital

Confidential Financial Evaluation

Account #:_____

Last Name _____ First _____ Middle Initial _____

Date of Birth _____ Social Security # _____ Telephone #: _____

Address: _____ How long? _____
City State Zip Code

List Spouse and Children living in household: Last Name	First Name	Date of Birth	Social Security Number	Monthly SSI/SSD Income Received for Each Person

Have you qualified for financial assistance at Blount Memorial in the last 12 months? _____

Have you filed or are you considering a lawsuit that may include your hospital bill? _____

Employer _____ Date of Hire _____ Telephone # _____

Hourly Wage _____ Hours worked per week _____ Monthly Income _____

Spouse Employer _____ Date of Hire _____ Telephone# _____

Hourly Wage _____ Hours worked per week _____ Monthly Income _____

If you are self employed, please complete the following:

Self Employment Name of Person	Type of Business or Profession including Product or Service	Total Receipts or Sales	Average Monthly Profit
Copy of Quarterly IRS 1040 forms and previous year Schedule C Profit or Loss from Business must be provided			

Are you an adult living with your parent/guardian or family member? _____

Does your parent/guardian claim you as an IRS dependent? _____ If yes, please provide the following:

Father's Hourly Wage _____ Hours worked per week _____ Annual Income _____

Mother's Hourly Wage _____ Hours worked per week _____ Annual Income _____

Other Income (please provide monthly amount received from any of these)

Food Stamps	SSI / SSD	Other Disability	Unemployment
$	$	$	$
Child Support	**Alimony**	**Retirement / Pensions**	
$	$	$	

Who pays or assists you in paying for your household expenses: _____

Blount Memorial Hospital

ASSETS

Please provide an estimated balance for the following:

Regular Checking	**Regular Savings**	**Stocks / Bonds**	**Money Market**
$	$	$	$0.00
CDs	**HSA / HRA / FLEX Spending Acct**	**401K / IRA / TSA / Retirement Savings**	
$	$	$	

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:	0	0	**Total:**	0	0

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.

Please sign below either electronically by tying in you name or print and sign. Once completed please save and email to business_office@bmnet.com

My typed name below shall have the same force and effect as my written signature.

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