

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](mailto: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. 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 <b>IRS 1040</b> filed for your household. If you didn't file a return, please explain why:
		<b>If you are self-employed</b> include all the following:
		<u>Schedule A – Itemized Deductions</u>
		<u>Schedule C – Profit or Loss from Business</u>
		<u>Schedule 1 – Additional Income and Adjustments to Income</u>
		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
		<b>If you have investments,</b> 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 <b>bank statement</b> (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 <b>pay stub showing year-to-date earnings</b> for you <b>and your spouse.</b>
		Copy of Separation Notice from employer or unemployment pay stubs
		Copy of <b>food stamp</b> eligibility letter and housing assistance approval letter (or other state assistance that applies).
		Copy of VA benefits, disability
		<b>If you have applied for Social Security benefits,</b> a copy of <u>Application Summary for Supplemental Security Income</u> (include all pages)
		<b>If you are unemployed,</b> a written, <b>notarized statement</b> concerning your current income status from a resident relative or parent ( <i><b>This is required if you have no household income.</b></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.

## Confidential Financial Evaluation

Account #: \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ How long? \_\_\_\_\_

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

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: \_\_\_\_\_



## ASSETS

Please provide an estimated balance for the following:

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

<i>Property and Equipment (a copy of your Mortgage Statement is required)</i>	<i>Property Assessment Value</i>	<i>Outstanding Debt/Liability</i>	<i>Net Value (Market Value less Debt)</i>
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) <b>Medical Bills</b>		
<b>Total:</b>			<b>Total:</b>		

To the best of my knowledge the following information is factual. I acknowledge that in accordance with Statute 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 typing in your name or print and sign. Once completed please save and email to [business\\_office@bmnet.com](mailto:business_office@bmnet.com) with other required documents.

**My typed name below shall have the same force and effects 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**