FINANCIAL ASSISTANCE APPLICATION

MAURY REGIONAL HEALTH

Dear Maury Regional Patient,

This packet includes:

1. Application packet instructions
2. Supporting documentation requirements
3. Financial aid application

Applications are processed upon the information provided. Please allow up to six (6) weeks to process your application. Eligibility is based on the Federal Poverty Income Guidelines. Collection will continue on your account until the required documentation is returned to Maury Regional Hospital. If the supporting documentation is not submitted with the application and/or falsification of any portion of the application is identified, your application will be denied. Maury Regional Hospital reserves the right to reverse financial assistance when information is presented indicating the patient/guarantor has the ability to pay for services and financial assistance should not have been approved.

All pertinent supporting documentation must be submitted to be considered for assistance. Incomplete applications will be rejected, and payment in full will become due. Once you've completed the application, please mail the entire packet to the address listed below.

Maury Regional Hospital
Attn: Patient Services
1224 Trotwood Avenue
Columbia, TN 38401

Contact info: Phone# 931-381-1111 ext 7262
Fax# 931-398-6512
Email: FinancialCounselor@mauryregional.com

***This program does not apply to all physicians or other professional fees billed separately from the hospital facility. It's your responsibility to contact your other providers to request financial assistance.**

MAURY REGIONAL HEALTH

SUPPORTING DOCUMENTATION: READ CAREFULLY

THE FOLLOWING **PROOF** OF INCOME/ASSETS THAT APPLY TO **YOU AND YOUR SPOUSE** AND ANY OTHER HOUSEHOLD DEPENDENT(S) IS REQUIRED.

- ***If you or your spouse are employed*** provide your 2 most recent and consecutive check stubs showing year to date gross income.
- ***If you or your spouse are self-employed*** submit all pages of your tax return for the previous year, including all Business Schedule forms.
- ***For those who draw Social Security*** provide award letter stating how much you receive for the current year. Social Security will send you a new one if needed, call 800-772-1213.
- ***If you draw retirement/pension*** provide a check stub, benefit statement, or W2.
- ***If you have no income*** you must provide:
  - Two notarized letters: one from whoever is helping you with food, shelter, and other financial support with explanation and a second notarized letter from a non-family member who lives outside your home validating your financial situation.
  - Provide a copy of your last tax return. A tax transcript from IRS.gov is accepted.
  - If you are a full time student provide a copy of your current transcript.
- ***Two months (60 days) current and consecutive bank statements*** for all bank accounts (checking, savings, etc). All statements must include the account holders name and address and the bank name/logo for identification purposes. Give a brief explanation of any deposits over $500.00.
- ***Two months (60 days) of statements for any investment accounts*** For example: CDs, stocks, bonds, IRA, 401k, 403b, etc.
- ***Two months (60 days) of statements for any payment apps*** For example: Paypal, CashApp, Venmo, Square Inc, GooglePay, MetaPay, etc.
- ***If you have applied for social security disability*** *but* have not yet received a decision or received a denial, include a copy of the most recent disability correspondence (application confirmation, letter from lawyer, social security office letter, disability determination letter, etc.)
- ***If you are receiving short term or long term disability*** provide your 2 most recent check stubs or a letter from your employer stating how much you receive and for how long.
- ***If you have been laid off from work*** provide unemployment award letter.
- ***If you are on Worker's Compensation*** you must provide proof of approval of worker's compensation benefits.
- ***If you receive child support or alimony*** provide the court order showing how much you receive.
- ***If you receive SNAP benefits (Supplemental Nutritional Assistance Program formerly known as Food Stamps) or other government support*** you must provide proof of the amount (a copy from the Department of Human Services).
- ***Claiming dependents*** Proof of dependents listed on application, provide the dependent page from your taxes.

FINANCIAL ASSISTANCE APPLICATION

MAURY REGIONAL HEALTH

FULL NAME OF PERSON APPLYING:_____

SOCIAL SECURITY NUMBER:_____ **DATE OF BIRTH**:_____

ADDRESS:_____**HAVE YOU MOVED IN THE LAST 60 DAYS?** _____

CITY:_____ **STATE**:_____ **ZIP CODE**:_____

PRIMARY PHONE:_____ **SECONDARY PHONE**:_____

ARE YOU A U.S. CITIZEN? □ Yes □ No (must provide proof of legal immigration status)

MARITAL STATUS (please check the appropriate box)

□ Married □ Divorced □ Single □ Widow/Widower

□ Legally Separated (must provide court documentation to prove separation)

HEALTH INSURANCE COMPANY NAME:_____

IS THIS A COBRA INSURANCE POLICY? □ Yes □ No

*IF YOU DON'T HAVE HEALTH INSURANCE TODAY, WHEN WAS THE LAST TIME YOU HAD IT?*_____

HAVE YOU EXPERIENCED ANY RECENT CHANGES SUCH AS (please check the appropriate box)

□ Marriage □ Divorce □ Birth □ Adoption □ Moved □ Lost insurance □ Denied Medicaid

□ Change in income □ Released from jail/prison □ Gained U.S. citizenship □ Gained/became a dependent □ None

HAVE YOU APPLIED FOR TENNCARE/MEDICAID? □ Yes □ No □ Not sure

WERE YOU IN FOSTER CARE AT AGE 18? □ Yes □ No

ARE YOU OR ANYONE IN YOUR HOUSEHOLD PREGNANT? □ Yes □ No **If yes, please provide proof.*

DO YOU OR SOMEONE IN YOUR HOUSEHOLD HAVE HIGH DOLLAR MEDICAL BILLS? □ Yes □ No

DO YOU HAVE A RECENT DIAGNOSIS OF BREAST/CERVICAL CANCER OR ESRD? □ Yes □ No **If yes, please circle which one.*

APPLICANT'S EMPLOYMENT STATUS (please check the appropriate box)

□ Employed full time □ Employed part time □ Self-employed □ Not employed □ Retired

□ Deemed disabled by social security administration □ Applied for social security disability □ Currently on FMLA

□ Receiving income from short term disability policy □ Receiving income from long term disability policy

APPLICANT'S CURRENT/ MOST RECENT EMPLOYER:_____**YEARS EMP OR HIRE DATE**:_____

SPOUSE'S EMPLOYMENT STATUS (please check the appropriate box)

□ Employed full time □Employed part time □ Self-employed □ Not employed □ Retired

□ Deemed disabled by social security administration □ Applied for social security disability □ Currently on FMLA

□ Receiving income from short term disability policy □ Receiving income from long term disability policy

SPOUSE'S CURRENT/ MOST RECENT EMPLOYER:_____**YEARS EMP OR HIRE DATE:**_____

FINANCIAL ASSISTANCE APPLICATION

MAURY REGIONAL HEALTH

FAMILY INFORMATION: *Please list all the people in your household. If you need additional space please use a separate sheet.*

NAME	DATE OF BIRTH	RELATION	SOCIAL SECURITY NUMBER

INCOME: *Please list the monthly amount.*

SOURCE	AMOUNT	SOURCE	AMOUNT
Social Security	$	Investment/Rental Income	$
Retirement	$	SNAP Benefits	$
Wages	$	Alimony and/or Child Support	$
Self-Employment Income	$	Unemployment	$
VA Benefits	$	Workers Comp	$
OTHER INCOME (please explain) $			

ASSETS AND RESOURCES: *Please list all that apply for the entire household.*

ASSET	MARKET VALUE	ASSET	MARKET VALUE
Checking Acct Balance	$	IRA/403b/401k Balance	$
Savings Acct Balance	$	Stocks/Bonds Balance	$
Vehicle #1	$	2nd Home and/or Rental Properties	$
Vehicle #2	$	Boat/ATV/Motorcycle/Camper	$
Vehicle #3	$	Other	$

EXPENSES: *Please list monthly amounts below.*

Rent/Mortgage	$	Other Loans	$
Phone	$	Health/Life Insurance	$
Cable	$	Home Insurance	$
Utilities	$	Auto Insurance	$
Alimony	$	Medication	$
Child Support	$	Food	$
Auto Loans	$	Other	$

I hereby request that Maury Regional Hospital, d/b/a Maury Regional Medical Center, make a written determination of my eligibility for financial assistance for services rendered. I understand that the information that I submit is subject to verification by Maury Regional Medical Center. I also understand that if the information that I submit is determined to be false, that my request for financial assistance will be denied and the charges for services rendered will be my full responsibility.

I hereby do affirm that the information contained in this application is accurate and I authorize Maury Regional Hospital d/b/a Maury Regional Medical Center to use information on my credit report in their process of determining my eligibility for their Financial Assistance Program

SIGNATURE_____ **DATE** _____

*Application must be signed by the applicant or applicant's spouse.
**If you are signing on the applicant's behalf and are not a spouse, you must send a complete copy of power of attorney.