Patient Financial Assistance Services
620 Skyline Drive
Jackson, TN 38301
Phone: 731 541 5000
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Email: pfas@wth.org

PATIENT FINANCIAL ASSISTANCE SERVICES — APPLICATION FORM

The completion of this application is necessary for determination of eligibility for charity care or financial need discount programs with West Tennessee Healthcare ("WTH"). Supplemental information is required in addition to this application in order to make a full determination of eligibility. The application should be completed fully and accurately; misleading or incomplete information may result in denial of future eligibility for any financial assistance with WTH.

Submission of this application should be accompanied by proof of the past 12 months' income for each household member, as outlined in Section 4. If the applicant is currently or recently unemployed, a ZERO AND SUPPLEMENTAL INCOME FORM should be included as well.

SECTION 1: APPLICANT INFORMATION					
PATIENT NAME:					
FACILITY NAME, and GUARANTOR/ ACCOUNT NUMBER:					
PATIENT ADDRESS STREET, CITY, STATE, AND ZIP CODE:					
DOB:		**SSN:**		**TELEPHONE #**	

SECTION 2: MEMBERS OF THE HOUSEHOLD

Please complete the following information for yourself as well as each other person who currently lives at your place of residence. Members of the household are defined as all persons who are considered dependent for personal reasons or for IRS tax filing requirements. Income is also required for all unmarried, household partners and their dependents.

NAME	DOB	RELATIONSHIP	CURRENTLY EMPLOYED? (Y OR N)	EMPLOYED IN THE PAST 12 MONTHS? (Y OR N)	CURRENT AND PAST EMPLOYER NAME (FOR PAST 12 MONTHS)

SECTION 3: BANKING, NON-RETIREMENT INVESTMENTS, AND OTHER ASSETS				
CHECKING ACCOUNT	Does anyone above have a personal checking account? YES ☐ NO ☐			
	Name of Bank(s):		**Cumulative Balance:**	
SAVINGS ACCOUNTS	Does anyone above have a Savings Account? YES ☐ NO ☐			
	Name of Bank(s):		**Cumulative Balance:**	
OTHER ASSETS	Do you own real property (other than primary residence)? YES ☐ NO ☐		If Yes, in which County and State?	
NON-RETIREMENT INVESTMENTS (e.g. non-IRAs, 401k, etc.)	Do you have non-retirement investments? YES ☐ NO ☐		If Yes, what is the name of fund and current balance?	
	If yes, please provide the most current 3 months of the investment's statements.			

SECTION 4: GROSS ANNUAL INCOME – PAST 12 MONTHS FOR EACH MEMBER OF HOUSEHOLD

Gross annual income is the amount of income earned prior to any deduction for taxes, healthcare, or any other deductions from payments and/or benefits. Examples of account income include (but may not be limited to) payroll or wages, tips earned, Social Security, disability income, alimony, child support, proceeds from benefit plans, cash gifts, grant income, or any other form of earned income. **Proof of the past 12 month's income is required for all members of the household listed in Section 2 of this application.** If the applicant or other members of the household claim no income, the Certification of Zero Income Form must be completed. **Acceptable proof of income is: proof of receipt of food stamps (all household members), payroll check stubs with year-to-date earnings, immediate previous year's federal tax return, copies of unemployment benefit letters indicating individual amounts of benefits received, and/or acceptable attestation of payment amounts and frequency from employers and renderers of cash gifts.** In the case of self-employed applications, documentation of income and expenses for any time period not covered by the provided tax return is required. Completion of the IRS Form 4506-T may be required for the applicant or household members.

HOUSEHOLD MEMBER	SOURCE OF INCOME	AMOUNT RECEIVED	FREQUENCY OF PAYMENT	FORM OF PROOF ATTACHED

SECTION 5: APPLICANT CERTIFICATION

I certify that all the information provided on this form and the previously approved application is true and accurate to the best of my knowledge. I understand that providing false, misleading, or incomplete information may result in the denial of this application and denial of eligibility for any financial assistance programs with WTH. Furthermore, I understand that providing false representations of the information contained on this application constitutes an act of fraud. I hereby authorize WTH to make inquiries necessary to verify the information contained in this application and I authorize WTH to release this information to any Business Associates or governmental agencies that may require it. I understand that the completion of this form is no guarantee of financial assistance and any extensions of assistance are not indefinite. I understand that future applications or recertification may be required.

Applicant's Name, and Signature	Date

ATTESTATION

If someone assisted the above applicant in the completion of this application, please complete the following

Name and Relationship	Date	Telephone Number

INTERNAL USE ONLY: _____