Ballad Health Application for Financial Assistance

Application Date: _____

Patient's Name: _____ Social Security #: _____ DOB: _____ Guarantor #: _____

Account Number(s) _____, _____, _____, _____

Please provide all documentation listed below that applies, sign and return to address listed below. Documentation should include all family members in the household. *Attach parent's information if patient is under the age of 18 and/or if the dependent is full-time student and claimed on parents tax return.

<u>Required Documentation</u> (*DO NOT send originals* Please use black ink)

- ❑ If you are unemployed and have no income, you must provide verification of your circumstances. Verification can be provided by a written statement from your physician, pastor, or attorney on letterhead. If you have a pending Supplement or Social Security Claim, please provide a letter from Social Security or disability attorney.
- ❑ If you are employed, you will need to provide W-2, current and prior 2 months pay stubs. Letter from the employer on company letterhead if W-2 and/or pay stubs are not available.
- ❑ Current and previous Federal Tax Return is required. If you are self-employed this includes the schedule C.
- ❑ If you have not filed taxes in either of the past two years, please complete and return Form 4506-T to the IRS to obtain verification of non-filing, or visit the www.irs.gov website and request a transcript of non filing. If you do not have internet services you can mail or fax your 4506-T form to the address/phone number listed on the 2nd page for your state. For additional information please visit www.irs.gov.
- ❑ If you are drawing Social Security, SSI, Social Security Disability, Veteran or Military Pension, you will need to provide verification of that income. Verification can be provided by supplying a copy of your most recent check, or letter from the government showing the amount you are drawing. If your minor children also receive a check, you must provide verification of their income as well.
- ❑ If you are drawing a retirement check, pension, annuity, short/long term disability, or worker's compensation, you will need to provide verification of that income. Verification can be provided by supplying a copy of your most recent check or letter from the income source.
- ❑ If you receive Food Stamps or AFDC (Aid for Dependent Children) you will need to provide Certification letter.
- ❑ If you receive child support, alimony, or receive any assistance from your children's other parent (not living in the household), you will need to provide verification of that income source. Verification can be a copy of your child's support order or divorce decree.
- ❑ If you are unemployed and drawing unemployment benefits, you will need to provide verification of the amount you receive. Verification can be unemployment benefit approval letter.
- ❑ If you are separated and/or going through a divorce you will need to provide legal proof of the separation; otherwise we will need spouse information.
- ❑ If your monthly expenses exceed your income, you will need to provide verification of how your monthly expenses are being satisfied. Verification can be letters of support from your family, friends, church, or other supporting organizations. If you are using credit cards, cash advances, or loans to satisfy your monthly expenses, you will need to provide copies of the most recent statement of those items.
- ❑ Proof of cash value of Stocks, Bonds or 401K.
- ❑ List all assets such as real estate, rental income, investment equity, vehicles, boat, recreational vehicles, etc.
- ❑ Provide the most recent copy of your and your spouse's checking, savings, (HSA) health savings and certificates of deposits. Include all pages of statements. If the bank account has been closed, please provide letter from bank stating that the account has been closed.
- ❑ Copy of police report if involved in motor vehicle accident.
- ❑ Proof if third-party benefits exhausted.
- ❑ Medicaid approval or denial letter, if applicable.

<u>Determining Eligibility</u>

Ballad Health will determine financial assistance eligibility based primarily on Federal Poverty Income Guidelines. Approved applications will be used for Ballad Health accounts **ONLY.**

<u>Continued Collections During Your Application Process</u>

Please note that extraordinary collection actions on your account will be suspended during the consideration of a completed charity application. You will have 30 days from the date of the financial application to provide all supporting documentation or your account will be released for billing. If the supporting documentation is not provided with the financial statement and/or there is any falsification of any portion of the application, your application will be denied. Ballad Health has the right to reverse its decision concerning financial assistance when information is presented that indicates the patient/guarantor has or had the ability to pay for their services and financial assistance should not have been approved.

If you need assistance in completing this application, please visit the Single Billing Office, a Ballad Health facility/office or call 423-408-7400 or 888-288-5174, Monday – Friday, 8:00 a.m. to 4:30 p.m.

Mailing Address: Ballad Health
Single Billing Office
105 W. Stone Drive, Suite 6A
Kingsport, TN 37660

Rev. 3-26-18

Patient/Responsible Party Information (Please Print)

Patient Full Name	Date of Birth	Responsible Party (Spouse/Guardian/Guarantor)
Address (Physical Address)	Zip Code	City

Social Security No.	Home Telephone No.	Married ( ) Single ( ) Separated ( ) Divorced ( )

Own your home ( ) Rent ( ) Landlord's Name	Mo. Pmt	Approximate Value $

Employer (Name & Address) ❑ Unemployed	Tel. #	Emp. Since	Mo. Income

Does Employer offer Medical Insurance? Yes ( ) No ( )
If offered and you do not subscribe, please indicate reason.

Are you on disability? No ( ) Yes ( ) How long?_____ Are you a veteran? No ( ) Yes ( ) Branch_____

Are any of the accounts listed due to a motor vehicle accident or any other personal injury? Yes ( ) No ( )
If yes, please provide the following info: Insurance Company/attorney/person asserted to have caused injury:
Policy Number:_____ Agent Name:_____ Phone Number:_____ Fax Number: _____

Spouse Information

Name:	Social Security No.	Does employer offer Medical Insurance? No ( ) Yes( ) If offered and you do not subscribe, please indicate reason,

Employer (Name and Address) ❑ Unemployed	Tel. #	Emp. Since	Mo. Income

Dependants

Name	Date of Birth	Relationship	Name	Date of Birth	Relationship

Monthly Expenses	
Mortgage/Rent Pmt	$
Electric	$
Water	$
Telephone/Cell	$
Food Expense	$
Clothing	$
Home-Auto Ins	$
Life/Burial Ins	$
Hospital Pmt	$
Alimony/Support	$
Child Care	$

Monthly Expenses	
Auto Payment (s)	$
Bank Loan	$
Finance Co	$
Credit Cards	$
Medications	$
Cable TV	$
Home Ins	$
Health Ins	$
Physician Pmt	$
Other (Specify)	$
Other (Specify)	$
Total Mo Expenses:	**$**

Monthly Income	
Patient	$
Spouse	$
Dependent (s)	$
Social Security	$
Disability	$
Unemployment	$
Child Support	$
Rental Income	$
Public Assistance	$
Alimony	$
Food Stamps	$
Worker's Compensation	$
Military Allotments	$
Dividends, Interest	$
Pensions	$
Other Income	$
Total Income	**$**

Assets	
Checking Account	$
Savings Account	$
Health Savings Account	$
Certificates of Deposit	$
IRAs	$
Land/Property other than home living in	$
Other	$

Additional Assets	Estimated Value
Auto #1	$
Auto #2	$
Motorcycle #1	$
Motorcycle #2	$
Boat	$
Recreational Vehicle	$

Total Number in Household:	

Applicant's statement: I do hereby certify that the information on this form is correct and true to the best of my knowledge & that no pertinent items of information have been concealed or omitted from this application. I also understand that Ballad Health has the right to reverse its decision concerning charity discounts when discovery of information is made that indicates the patient/guardian/guarantor has or had the ability to pay for their services. I am giving Ballad Health permission to access my credit file and to provide my financial information to those companies contracted by Ballad Health for the purpose of financial or product recovery programs for which I may qualify.

Patient/Guardian/Guarantor Signature _____ **Date** _____

Comments:

_____

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