

Mountain States Health Alliance recognizes there can be a need for financial assistance with individuals that have limited income in paying hospital bills. Eligibility for financial assistance is based on established criteria and the information contained in this application.

The purpose of this form is to collect information that will enable us to make an appropriate and fair determination of your financial needs. Please complete each item on the application and include the supporting documentation listed on page 2. It is extremely important that you complete this application upon receipt and return it within 10 days to the address below.

Mountain States Health Alliance
ATTN: Patient Accounts
P.O. Box 1817
Johnson City, TN 37605-1817

Patient Account Number(s)		
_____	_____	_____
_____	_____	_____

Patient Name							
<i>Last</i>		<i>First</i>		<i>Middle Initial</i>		Date of Birth	
Responsible Party			Social Security Number			Home Phone	
Address			City		State	Zip Code	
Employer <input type="checkbox"/> Unemployed					Work Phone		Are any of the accounts listed above due to a motor vehicle accident? <input type="checkbox"/> No <input type="checkbox"/> Yes
Number in Household		Does employer offer Medical Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes If offered and you do not subscribe, please indicate reason:					
Dependent(s) - Name & Age			Are you on disability? <input type="checkbox"/> No <input type="checkbox"/> Yes - How long? _____		Are you a veteran? <input type="checkbox"/> No <input type="checkbox"/> Yes - Branch _____		Annual Gross Household Income

Spouse's Name		Social Security Number (spouse)		Work Phone	
Employer (spouse) <input type="checkbox"/> Unemployed		Does employer offer Medical Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes If offered and you do not subscribe, please indicate reason:			

If you have any questions regarding this form, please contact Patient Financial Services at 423-431-1700 or Toll Free 1-877-281-5665.

Please provide proof of all income and assets noted on this page, including items 1, 2 and 3 (below). Your application cannot be considered without this information and will be returned to you if the information is not included with the application.

1. Current Pay Stub (Responsible party & spouse) **REQUIRED**

3. Checking & Savings Statements (one full month) **REQUIRED**

2. Last two complete Federal Tax Returns with profit and loss reportings **REQUIRED**

INCOME (Monthly)

Patient \$ _____
 Spouse \$ _____
 Dependent(s) \$ _____
 Public Assistance \$ _____
 Food Stamps \$ _____
 Social Security \$ _____
 Unemployment \$ _____
 Strike Benefits \$ _____
 Worker's Compensation \$ _____
 Alimony \$ _____
 Child Support \$ _____
 Military Allotments \$ _____
 Pensions \$ _____
 Income from: Rent,
 Certificates of Deposit,
 Dividends, Interest \$ _____
TOTAL: \$ _____

EXPENSES (Monthly)

Rent / Mortgage \$ _____
 Homeowner's Insurance \$ _____
 Property Tax \$ _____
 Electric \$ _____
 Gas / Propane \$ _____
 Water \$ _____
 Telephone / Cell Phone \$ _____
 Food \$ _____
 Car Payment \$ _____
 Car Insurance \$ _____
 Gasoline \$ _____
 Alimony / Support \$ _____
 Child Care \$ _____
 Clothing \$ _____
 Credit Cards
 (Total per month) \$ _____
 Loans \$ _____
 Medical Insurance \$ _____
 Life Insurance \$ _____
 Other \$ _____
TOTAL: \$ _____

ASSETS

Checking Account \$ _____
 Savings Account \$ _____
 Certificates of Deposit \$ _____
 IRAs \$ _____
 Investments \$ _____
 Stocks / Bonds \$ _____
 Land / Property other
 than home you live in \$ _____

Vehicles	Make	Estimated Value
Auto #1	_____	\$ _____
Auto #2	_____	\$ _____
Motorcycle #1	_____	\$ _____
Motorcycle #2	_____	\$ _____
Boat	_____	\$ _____
Recreational Vehicle	_____	\$ _____

If you report zero income, you must submit signed statements from individuals providing your room and board, signed statements attesting to your unemployed status and a signed statement explaining how your daily expenses are being covered with zero income to report.

Please list any other information you feel would be helpful to us in determining your eligibility for assistance in paying your hospital bill. Attach additional documentation, if needed.

I certify I have provided complete and accurate information in this application. I understand Mountain States Health Alliance may verify the financial information contained in this application in connection with the hospital's evaluation process and may run a credit history to verify the above information. I hereby authorize the hospital to contact my employer to certify the information provided and to request reports from credit reporting agencies. I understand that this information will be used to determine my eligibility for financial assistance and that falsification of information in this application will result in denial of any assistance.

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