COOKEVILLE REGIONAL
MEDICAL CENTER
It's the Way WeCARE

APPLICATION FOR FINANCIAL ASSISTANCE

Cookeville Regional Medical Center and affiliated entities is committed to care for all patients regardless of their ability to pay.

Patients who are unable to pay for services may be eligible for financial assistance.

Please complete and return this application to be evaluated for financial assistance.

I request that Cookeville Regional Medical Center and affiliated entities make a written determination of my eligibility for the Financial Assistance Program. I understand that the information that is provided concerning my annual income and family size may be verified by Cookeville Regional Medical Center and affiliated entities and their financial guidelines. I also understand that if the information provided is determined to be false, my financial assistance request may be denied and I will be responsible for all balances due to Cookeville Regional Medical Center and affiliated entities. This does not include any other fees outside of this facility.

To receive financial assistance approval, I understand that CRMC and affiliates expects all applicants to exhaust all other payment sources such as, but not limited to Medicaid or Disability. I also understand that while waiting for approval for financial assistance, CRMC and affiliates requires that good faith payments be made monthly towards my outstanding balances. This application is good for a period of six to twelve months depending on income source.

_____ _____

Patient / Guarantor | Date Signed

_____ _____

Hospital Representative | Date Signed

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Account #: _____ Last Name: _____

What you need to include with your completed application.

Referring to the list below, please send in copies of all documents that apply. We have enclosed a self-addressed stamped envelope for your convenience. **You must return this information to us within 30 days for your application to be considered for review.**

IF YOU OR YOUR SPOUSE WORK

- ❑ Last two months bank statements
- ❑ Last three pay stubs for you and your spouse
- ❑ Child Support and/or Alimony income
- ❑ W2 from employer for last calendar year
- ❑ Income tax return for last year
- ❑ Copy of Food Stamp Letter
- ❑ Document you have applied for Disability
- ❑ Signed Statement with phone number of anyone helping you financially and what they are helping you with.
- ❑ Doctor's excuse for not returning to work for an extended time
- ❑ Copy of Denial Letter from Tenncare
- ❑ Other: _____

IF YOU ARE UNEMPLOYED

- ❑ Last two months bank statements
- ❑ Copy of Social Security or Disability Check or benefits letter (unless listed on your bank statement)
- ❑ Child Support and/or Alimony income
- ❑ Copy of Food Stamp Letter
- ❑ Document you have applied for Disability
- ❑ Copy of Denial Letter from Tenncare
- ❑ Signed Statement with phone number of anyone helping you financially and what they are helping you with.
- ❑ Doctor's excuse for not returning to work for an extended time
- ❑ Other: _____

IF YOU OR YOUR SPOUSE ARE RETIRED

- ❑ Last two months bank statements
- ❑ Copy of Social Security or Disability Check or benefits letter (unless listed on your bank statement)
- ❑ Child Support and/or Alimony income
- ❑ Copy of Food Stamp Letter
- ❑ Signed Statement with phone number of anyone helping you financially and what they are helping you with.
- ❑ Other: _____

If you cannot provide this information please contact us immediately to see if an alternate form of income verification can be used. Please note that it may take up to 150 days to process your application. If you have any questions or comments, please do not hesitate to call us at (931) 783-2360.

FOR HOSPITAL USE ONLY

Insurance: _____ Percentage: _____ Expiration Date: _____

$250.00 - $4999.99	Business Office Director	❑ Approved	❑ Denied	Initial _____ Date _____
> $5000.00	Administrator	❑ Approved	❑ Denied	Initial _____ Date _____

If denied, reasons(s):

_____

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PATIENT INFORMATION

Guarantor Name:_____

DOB: _____ Age: _____ Guarantor SSN:_____

Guarantor Address: _____

City: _____ State:_____ Zip: _____

Guarantor Home / Cell Phone: _____ Work Phone: _____

Employed: ❑ Yes ❑ No ❑ Full-Time Hrs:_____ ❑ Part-Time Hrs: _____

Employer Name: _____

Occupation: _____ How long employed: _____

How much per hour: $_____ If not employed please indicate time frame: _____

Disabled: ❑ Yes ❑ No Are you receiving disability benefits? ❑ Yes ❑ No

Have you applied for disability? ❑ Yes ❑ No Date:_____

Do you have health insurance? ❑ Yes ❑ No

Please indicate what type of insurance you have or why you do not currently have insurance:

_____

SPOUSE INFORMATION

Spouse Name:_____

DOB: _____ Age: _____ Spouse SSN:_____

Employed: ❑ Yes ❑ No ❑ Full-Time Hrs:_____ ❑ Part-Time Hrs: _____

Employer Name: _____

Occupation: _____ How long employed: _____

How much per hour: $_____ If not employed please indicate time frame: _____

Disabled: ❑ Yes ❑ No Are you receiving disability benefits? ❑ Yes ❑ No

Have you applied for disability? ❑ Yes ❑ No Date:_____

Do you have health insurance? ❑ Yes ❑ No

Please indicate what type of insurance you have or why you do not currently have insurance:

_____

PLEASE INDICATE ANYONE ELSE LIVING IN THE HOME WITH YOU:

NAME	DOB	RELATIONSHIP

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Must be returned within 30 days. All information must be completed for application to be processed.

INCOME AMOUNT RECEIVED MONTHLY

Wages	$	Self-Employment Earnings	$
Public Assistance	$	Social Security	$
Unemployment	$	Workers' Compensation	$
Alimony	$	Child Support	$
Retirement Benefits	$	Incomes from Dividends	$
Food Stamps	$	Other:	$

OTHER ASSETS

Property other than home?	❑ Yes ❑ No	Value	$
Inheritance Amount	$	IRA / 401K	$
IRA / 401K	$	CDs / Bonds	$
Other Assets:			$

AMOUNT YOU PAY MONTHLY

Rent / Mortgage	$	Water	$
Electric / Gas	$	Groceries	$
Satellite / Cable	$	Internet	$
Home Phone	$	Cell Phone	$
Health Insurance	$	Vehicle Insurance	$
Medications	$	Total Outstanding Medical Bills	$
Alimony	$	Child Support	$
Credit Card	$	Credit Card	$

VEHICLE

VEHICLE

Year / Make / Model		Year / Make / Model	
Monthly Payment	$	Monthly Payment	$

Please use the space below to tell us any special situation that we may need to know to process your Financial Application. Tell us if there is no income in the household and how you are paying your bills.