FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS

Erlanger has a financial assistance policy (FAP) that provides free care (financial assistance) to those who qualify. You should review the full policy for further information (available at www.erlanger.org/fap). On the reverse, please find the application form. **Please note that FA is determined by looking at Family Income (before taxes and deductions) and Assets**. Please see the policy for a definition of Family Income, but, generally, all persons who are related by blood or marriage and who reside together are considered Family. **In addition to filling out the attached form, you must provide all the following documentation for your application to be complete:**

- The complete, signed tax returns for all Family members from the most recent tax year with all pages and schedules.

AND

- Two recent pay stubs from each Family member. If any Family member receives any benefits from Social Security, a copy of the award letter for the current year must also be provided.

AND

- Three months of bank statements (all pages) for all bank, checking, savings, investment or other depository accounts in which a Family member has an ownership interest or withdrawal, signing or check writing authority.

AND

- A list of any potential claims or pending lawsuit that may result in the recovery of money or property for a patient or Family member.

Per the policy we may request additional information for verification and clarification purposes, as needed. If you do not have all of the required documentation and want to discuss acceptable alternatives, have questions about FA or would like assistance in applying please contact us at the telephone numbers below. **You may email, upload it to myChart, or mail your completed application form with all required documents to**:

Erlanger Financial Assistance
975 E 3rd Street
Box 243
Chattanooga, TN 37403
423-778-9805
charity.applications@erlanger.org

Patient Financial Services (PFS)
3990 E. US Hwy. 64 Alt.
Murphy, NC 28906
828-835-3662/ 828-837-3897

Please note that Erlanger or its agents will verify any information provided. Any misleading, incomplete or fraudulent applications will be denied. Providing fraudulent, significantly inaccurate, or incomplete information may result in the revocation of financial assistance if such inaccuracies are discovered after financial assistance has been approved.

Additionally, any information you provide may be used to seek payment for medical bills, including, but not limited to, screening for other insurance or programs.

ERLANGER HEALTH FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____

Provide additional pages with information, if more space is required to answer any of the following:

RESPONSIBLE PARTY			
Name	Marital Status	DOB	Social Security Number
Street Address, City, State and Zip		How long at this Address?	Home Phone No.
Employer Name and Address		Business Phone No.	Position/Title & Length of Employ.

SPOUSE		
Name	DOB	Social Security Number
Employer Name and Address	Business Phone No.	Position/Title & Length of Employ.

HOUSEHOLD INFORMATION (All Persons in Household, Including Applicant and Spouse)			
Name	DOB	Relationship	Employer and Gross Monthly Income (including SS, Disability, Child Support, Alimony, Wages, Dividends, Rents, Profits, Draws, Distributions)

Total Persons in Household:	**Total Household Monthly Income Before Taxes:**

Estimated Household Monthly Living Expenses:

Do you or anyone in the household have any potential claims or pending lawsuits that might result in the recovery of money or property for you or a household member? If so describe:

HOUSEHOLD ASSETS (value)		
Checking & Savings: $	Investments: $	CDs: $
IRA/401(k): $	Other: $	Business Ownership: $

Do you or any Household member own any real estate? If so, list the owner(s), address(es), value(s) and any amount owed on a mortgage.

Is any Household member the beneficiary of a trust? If so, identify the trust, the trustee and contact information, and describe any distributions.

HOUESHOLD MOTOR AND RECREATIONAL VEHICLES (Cars, Trucks, RVs, Boats, Motorcycles, etc.)			
Year, Make, Model and Owner	Monthly Payment	Current Value	Current Amount Owed

I hereby affirm and attest that my application (including required documents) is true, complete and correct. I consent for Erlanger or its agents to verify any information I provide – through credit report checks or similar searches -- and to use such information in seeking payment for medical bills, including, but not limited to, screening for other insurance or programs.

Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Relationship if other than the Patient: _____

*****Attach Required Documentation as described in the Instructions for a complete application*****