FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS

Erlanger has a financial assistance policy (FAP) that provides for free care (financial assistance) to those who qualify. You should review the full policy for further information.

All persons, whether insured or uninsured, may apply for financial assistance. On the following page, please find the application form. <u>Please note that FA is determined by looking at Family Income</u> (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 the filling out the attached form, you must provide <u>all</u> of the following documentation for your application to be complete:

The most recent tax returns for all Family members. This includes tax returns for both spouses
who do not file jointly and tax returns for any related person who is required to file a tax return
and who resides in the same household. If any member of the family is self-employed or the
owner of a business, he or she must also provide Schedule C, Schedule F, and Schedule K-1
as applicable. A Family member may also submit a recent pay-stub instead of a tax return if he
or she has no other source of income other than the job reflected on the paystub.

<u>AND</u>

Most recent statements for any and 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.

<u>AND</u>

• 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.

Although not required, you may also include a letter with your application that describes any particular hardship or other information you think is relevant to the financial assistance determination.

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 PFS. After you complete the attached form, please mail it <u>with all required documents</u> to PFS.

Patient Financial Services (PFS)	Patient Financial Services (PFS)
1501 Riverside Dr., Suite 105	3990 E. US Hwy. 64 Alt.
Chattanooga, TN 37406	Murphy, NC 28906
423-778-3296	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 SYSTEM FINANCIAL ASSISTANCE APPLICATION

Patient	Name:
Patient	No :

Medical Record No.:

□ Future Treatment

This Application for FA is for (choose one):
Prior Treatment Provide additional pages with information if more space is required to answer any of the following:

RESPONSIBLE PARTY									
Name		Mari	Marital Status		Social Se	ecurity Number			
Address		H	How long at this Address?		Home Ph	Home Phone No.			
Employer Name and Address			Business Phone No.		Position/	Position/Title & Length of Employ.			
SPOUSE									
Name					Social Se	ecurity Number			
Employer Name and Address			Business Phone No.		Position/	Position/Title & Length of Employ.			
HOUSEHOLD INFORMATION (All Persons in Household)									
Name	DOB	F	Relationship (includi		er and Gross Monthly Income Ig SS, Disability, Child Support, Alimony, Dividends, Rents, Profits, Draws, Distributions)				
Total Persons in Household:			Total House	ehold M	onthly Inco	me 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:									
	HOUS	EHO	OLD ASSETS (valu	le)					
Checking & Savings: \$	Investm	ents:	\$	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.									
Year, Make, Model and Owner			Monthly Payment	Current	t Value	Current Amount Owed			
I hereby affirm and attest that my application (including required documents) is true, complete and correct. I consent for Erlange									
or its agents to verify any information I provide 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