WYTHE COUNTY COMMUNITY HOSPITAL
APPLICATION FOR ASSISTANCE

In order to complete processing of your application for financial assistance at WCCH, we will need a copy of the following items:

1. COPY OF CHECKING AND/OR SAVINGS ACCOUNT FOR THE **PREVIOUS MONTH**.

2. REAL ESTATE AND PERSONAL PROPERTY TAX TICKETS FROM THE **PREVIOUS YEAR**.

3. VERIFICATION OF **ALL** HOUSELHOLD INCOME FOR THE **PAST 90 DAYS:** INCLUDING SOCIAL SECURITY, DISABILITY AND SPOUSE'S INCOME.

4. DENIAL LETTER FROM DEPT OF SOCIAL SERVICES OR FIRST SOURCE STATING THAT YOU DO NOT QUALIFY FOR ASSISTANCE.

5. IF UNINSURED, A LETTER SHOWING THAT YOU APPLIED FOR INSURANCE THROUGH HEALTHCARE.GOV AND WERE UNABLE TO GET ASSISTANCE WITH PREMUM PAYMENTS.

6. COPY OF WYTHE CO COMMUNITY HOSPITAL BILLS YOU HAVE RECEIVED (IF ANY).

Before your application will be considered for assistance, all of the above must be provided (or a valid reason why it doesn't apply to you or your family) within 30 days from discharge date along with a **fully completed application**. When all information is received and eligibility is determined, your application will be submitted to the Director of Financial Services for approval.

Wythe County Community Hospital
PO Box 291569
Nashville, TN 37229-1569
Phone: 855-426-0148
Fax: 804-381-4508

Return Application by ___________

Financial Assistance Application

Applicant___________________________________ Date of Birth ___________________ Social Security Number _______-_____-_______

Address____

Telephone Number_________________________ **Please Circle One** Married Single Separated Divorced Widowed

If married or separated, please answer the following questions.

Spouse's Name ____ Date of Birth _____________ Social Security Number ______-_____-_______

<table>
<tr>
<td>Applicant

Are you currently employed?

_____ Yes

Hourly Pay Rate $_________

Hours Per Week _________

_____ No If no, please attach a copy of your unemployment benefits. If you do not receive unemployment benefits, please attach a letter explaining your means of support with a signature by the person providing the support.

Who was your previous employer?

____

Date last worked ______________</td>
<td>Spouse

Are you currently employed?

_____ Yes

Hourly Pay Rate $_________

Hours Per Week _________

_____ No If no, please attach a copy of your unemployment benefits. If you do not receive unemployment benefits, please attach a letter explaining your means of support with a signature by the person providing the support.

Who was your previous employer?

____

Date last worked ______________</td>
<td>Do either you or your spouse draw Social Security?

____ Yes If yes, please attach a letter from Social Security verifying how much you make per month.

Other Income

Child Support $_______________

Alimony $____________________

SNAP Benefits $_______________

Other $_______________________
➢ If other, please explain source of income given.
____

_____________________________________</td>
</tr>
<tr>
<td colspan="3">How many people live in your household? _________ Number of Dependents in household? ________

List full name and date of birth for each dependent.

1. Name____ Date of Birth_______________
2. Name____ Date of Birth_______________
3. Name____ Date of Birth_______________</td>
</tr>
</table>

Please list all property owned (Home, Land, Vehicles, etc.)

1. ____ Value $__________________________

2. ____ Value $__________________________

3. ____ Value $__________________________

4. ____ Value $__________________________

In order to process your request for financial assistance, we will need the following documents along with your completed application returned to the Patient Financial Counselor by the due date located at the top of the first page.

________ An itemized checking and savings account statement for the previous month
________ A copy of your most recent tax return
________ If you receive SNAP benefits, a copy of your award letter
________ Personal property tax tickets (Vehicles, home, land, etc.)
________ Check stubs for the previous three months
________ Denial letter from the Department of Social Services or First Source stating you do not qualify for assistance.
________ Exemption number and Application ID from Healthcare.gov

If for any reason you are unable to provide the documents requested, please explain:

I understand that this form will be used to evaluate my ability to pay my hospital bill(s). I agree to cooperate with Wythe County Community Hospital in pursuing reimbursement from any available insurance or other medical payment programs and in verifying the information on this form. I also understand that all or part of my indebtedness to Wythe County Community Hospital may be reduced if I qualify under the current Wythe County Community Hospital Charity Care Guidelines. Assignment of Benefits – I hereby assign to Wythe County Community Hospital, to such extent necessary to satisfy my outstanding indebtedness to Wythe county community Hospital or any of its affiliates, all sums payable to me pursuant to any health benefit, plan, policy or insurance (including but not limited to health, liability, uninsured or underinsured motorists, or medical payments insurance) and/or pursuant to any settlement or judgment arising out of or related to any incident which caused or causes my admission or medical treatment. This Assignment is given in consideration of medical services rendered to date, in consideration of Wythe County community Hospital considering the reduction of my indebtedness under the Wythe County Community Hospital Charity Care Program and in consideration of future care which may be rendered to me or members of my household. I hereby certify that the information contained on this questionnaire is correct and accurate and I hereby authorize any and all parties to release any information necessary to confirm any information on this questionnaire including the amount of my assets and income. I further authorize and agree that Wythe County Community Hospital or its affiliates may obtain personal credit reports with respect to me. If any I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature ____

Date ______________________

Patient Financial Services Director ____

Date ______________________

Application can be submitted in person or by mail to the following address:

For any questions please contact our Benefits Advisor at **(276) 228-0245.**

Wythe County Community Hospital
Attn: Charity Approval Department
P.O. Box 291569
Nashville, TN 37229-1569