Financial Assistance Application

****Financial assistance can only be used for accounts that are 3 months or less old****

Before your application will be considered for assistance, all the requested documents must be provided (or a valid reason why it does not apply to you or your family) within 90 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.

Please send completed application and supporting documents to the following address:

Wythe County Community Hospital

Financial Assistance

PO Box 291569

Nashville, TN 37229-1569

Customer Service Phone: 1-855-426-0148

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:

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

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:

_____

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:

_____

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:

_____

_____

_____

How many people live in your household (including you)? _____ 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 _____
4. Name _____ Date of Birth _____

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

1. _____ Value $ _____
2. _____ Value $ _____
3. _____ Value $ _____
4. _____ Value $ _____

To process your request for financial assistance, we will need the following documents along with your completed application.

_____ 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 (home, land, vehicles, etc.)
_____ Pay stubs for the previous three months
_____ Denial letter from the Department of Social Services or First Source stating you do not qualify for assistance
_____ If uninsured, exemption letter and application ID from HealthCare.gov
_____ Copy of Wythe County Community Hospital bills you have received (if any) that pertain to the time frame in which you are applying for financial assistance

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 reviewing 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 all parties to release any information necessary to verify 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. I understand that if any information provided proves to be untrue, the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature _____

Date _____

****Revised July 2021**