Financial Assistance Application

Please print clearly

Patient Last Name ______ First Name ______ Date of Admission ______

Name: ______ Relationship to Patient: ______

Street Address: ______

City/State/ZIP: ______

Number of years at this address: ______ ☐ Own ☐ Rent

Marital Status: ☐ Married ☐ Unmarried ☐ Separated

Name of Employer: ______

Years at This Job: ______ Hours Worked Weekly: ______ Position/Title: ______

Social Security Number: ______ Home Ph: ______ Business Ph: ______

Dependents

Number of Dependents: ______ Ages: ______

Spouse / Co-Applicant

Name: ______ Relationship to Patient: ______

Street Address: ______

City/State/Zip: ______

Number of years at this address: ______ ☐ Own ☐ Rent

Name of Employer: ______

Years at This Job: ______ Hours Worked Weekly: ______ Position/Title: ______

Social Security Number: ______ Home Ph: ______ Business Ph: ______

Gross Monthly Income

APPLICANT		SPOUSE/CO-APPLICANT	
Employment (per hour)	$	Employment (per hour)	$
Social Security	$	Social Security	$
Disability	$	Disability	$
Net Rental Income	$	Net Rental Income	$
Unemployment Comp.	$	Unemployment Comp.	$
Child Support/Alimony	$	Child Support/Alimony	$
Public Assistance	$	Public Assistance	$
Other	$	Other	$
Total	$	Total	$

Form No. 30786 (03/05/18) ss

Monthly Living Expenses

House Payment or Rent	$	Alimony	$
Second Mortgage	$	Insurance (Car)	$
Utilities	$	Insurance (Health)	$
Phone	$	Insurance (Life)	$
Food	$	Savings	$
Child Care	$	Medicine	$
Child Support	$	Other	$

Installment Debts

	Monthly Pymt.	Unpaid Balance	Comments:
Auto	$	$	
Bank	$	$	
Finance Co.	$	$	
Hospital	$	$	
Doctor	$	$	
Credit Cards	$	$	
Other	$	$	

MEDICAID	☐ Yes	☐ No	Comments:
Children's Special Services	☐ Yes	☐ No	______________________
Receiving Food Stamps	☐ Yes	☐ No	______________________

YOU MUST INCLUDE WITH THIS APPLICATION FORM:

- A copy of your 3 most recent pay stubs
- A copy of your last filed tax return

SPECIAL NOTE:
This application only applies to your child's hospital bills. Emergency room physicians, anesthesiologists, radiologist, all specialists bill separately. If you received a bill from them you must contact their specific office to follow their financial assistance policies. They are not automatically covered with this application.

I/we certify that the information given is correct to the best of my/our knowledge.

Signature of Applicant:______________________________

Spouse/Co-Applicant: ______________________________

Date:____________________ Witness:______________________________

Please return to:
East Tennessee Children's Hospital, Business Office, 2018 Clinch Ave., Knoxville, TN 37916
ATTN: Patient Financial Services