MARSHALL
MEDICAL CENTER

1080 N Ellington Parkway
Lewisburg, TN 37091

REQUEST FOR FINANCIAL ASSISTANCE

I hereby request that Maury Regional Hospital, d/b/a Marshall Medical Center, make a written determination of my eligibility for financial assistance for services rendered. I understand that the information that I submit is subject to verification by Marshall Medical Center. I also understand that if the information that I submit is determined to be false, that my request for financial assistance will be denied and the charges for services rendered will be my full responsibility.

If all information requested is not accurate, left blank, or not included, your application will be denied.

1. **FULL NAME:** _____

2. **ADDRESS:**_____ **CITY:**_____ **ZIP:**_____

3. **PHONE NO:**_____

4. **SOCIAL SECURITY NO:**_____ ***IF YOU DO NOT HAVE A SOCIAL SECURITY NUMBER, DOCUMENTATION IS REQUIRED TO SHOW PROOF OF U.S. CITIZENSHIP OR LEGAL IMMIGRANT STATUS.**

5. **MARITAL STATUS** (please check the appropriate box)
   - ☐ Married ☐ Divorced ☐ Single ☐ Widow/Widower
   - ☐ Legally Separated (must provide court documentation to prove separation)

6. **APPLICANT'S EMPLOYMENT STATUS** (please check the appropriate box)
   - ☐ Employed Full Time ☐ Employed Part Time ☐ Not Employed ☐ Retired
   - ☐ Disabled ☐ Applied for Disability

7. **EMPLOYER:**_____**YEARS EMP OR HIRE DATE:**_____
   IF NOT EMPLOYED TODAY, LIST WHERE AND WHEN YOU WERE LAST EMPLOYED:
   _____

8. **SPOUSE'S EMPLOYMENT STATUS** (please check the appropriate box)
   - ☐ Employed Full Time ☐ Employed Part Time ☐ Not Employed ☐ Retired
   - ☐ Disabled ☐ Applied for Disability

9. **SPOUSE'S EMPLOYER:**_____**YEARS EMP OR HIRE DATE:**_____
   IF NOT EMPLOYED TODAY, LIST WHERE AND WHEN YOU WERE LAST EMPLOYED:
   _____

10. **INSURANCE COMPANY NAME:**_____
    IF YOU DO NOT HAVE INSURANCE COVERAGE TODAY, HAVE YOU HAD COVERAGE IN THE PAST AND WHEN DID IT END?_____

11. **ARE ANY ACCOUNTS THE RESULT OF AN ACCIDENT THAT MAY BE COVERED BY AUTO INSURANCE, WORKER'S COMPENSATION OR LIABILITY? ☐ YES ☐ NO**
    (If the answer is YES, you must contact our office so we can file the insurance before those accounts can be considered for Financial Assistance.)

12. **ARE YOU ELIGIBLE FOR: TENNCARE/MEDICAID?** ☐ **YES** ☐ **NO** (YOU MUST BE INELIGIBLE FOR TENNCARE COVERAGE TO BE CONSIDERED FOR FINANCIAL ASSISTANCE.)

INSURANCE COVERAGE THROUGH THE MARKETPLACE? ☐ **YES** ☐ **NO**
You can apply over the phone @ 1-800-318-2596 or online at https://www.healthcare.gov/

13. **FAMILY INFORMATION:** *List all people that can be claimed as dependents including yourself.*

	NAME	DATE OF BIRTH	RELATION	AGE
A)	_____	_____	_____	_____
B)	_____	_____	_____	_____
C)	_____	_____	_____	_____
D)	_____	_____	_____	_____
E)	_____	_____	_____	_____

14. **INCOME:** *Check all that apply and include the monthly amount.*
***PROOF OF INCOME IS REQUIRED—see attached page for acceptable proof of income.**

SOURCE	AMOUNT	SOURCE	AMOUNT
☐ Wages	$_____	☐ Alimony/Child Support	$_____
☐ Social Security	$_____	☐ SNAP benefits (Food Stamps)	$_____
☐ Unemployment	$_____	☐ Rental Income	$_____
☐ Pension	$_____	☐ Other (**please explain**)	$_____

15. **ASSETS:** *Please list all that apply for the entire household.*

Liquid Assets

Checking Account Balance(s) $_____
Savings Account Balance(s) $_____
CDs/Bonds/Stocks/IRAs, etc. (total balances) $_____

Auto/Truck Assets

Make/Model/Year _____ Estimated Value $_____ Loan Balance $_____
Make/Model/Year _____ Estimated Value $_____ Loan Balance $_____

Property Assets

Home (residence) Fair Market Value $_____ Mortgage Balance $_____
Other Property:
(vacation, rental, etc.) Fair Market Value $_____ Mortgage Balance $_____

Other Assets

Other (ATVs, Boats, Motorcycles, etc.) List approximate value $_____

16. **EXPENSES:** *Please list the monthly amounts below.*
Please also list, on the back of the application, any other household or medical expenses. You may use a separate sheet of paper if necessary.

Rent/Mortgage	$_____	Auto Loan Payments	$_____
Phone/Cable	$_____	Other Loan Payments	$_____
Credit Cards	$_____	Alimony/Child Support	$_____

Utilities (gas, electric, water, etc.) $_____
Insurance (auto, home, life, medical, etc.) $_____
Other (**please explain**) $_____

I hereby do affirm that the information contained in this application is accurate and I authorize Maury Regional Hospital d/b/a Marshall Medical Center to use information on my credit report in their process of determining my eligibility for their Financial Assistance Program.
*Application must be signed by the applicant or applicant's spouse.
*If you are signing on the applicant's behalf and are not a spouse, you must send a complete copy of power of attorney document.

SIGNATURE_____ **DATE** _____

Proof of Income/Asset Requirements:

MAKE SURE THE FOLLOWING PROOF OF INCOME/ASSETS THAT APPLY TO YOU AND SPOUSE (IF APPLICABLE) IS PROVIDED OR YOUR APPLICATION WILL BE DENIED.

- ***Proof of Asset Requirements:***
  Please attach copies of your 2 most recent statements for all bank accounts, CDs (certificates of deposit), IRAs, stocks, bonds or other form of liquid assets listed on your application.

- ***For those who draw Social Security:***
  The 1099 form from the Social Security department, or the letter from Social Security showing how much you will be drawing for this year.

- ***If you have applied for disability***, but have not yet received a decision or received a denial, include a copy of disability correspondence (letter from lawyer, disability determination letter, etc.)

- ***If you have no income,*** list when and where you were last employed on this application. You must provide a **notarized** letter from whomever is helping you with food, shelter, and/or other financial support along with an estimate of the actual dollar amount or value amount of the assistance given. If you have had any income for the year, you must also provide proof of that income. If you are a full time student please provide a copy of your current transcript.

- ***If you draw retirement***, a copy of your retirement check or your **2 most recent and consecutive bank statements** if direct deposited.

- ***If you are employed,*** a copy of your W2, or a copy of the previous year's tax return. If you are applying in the month of June or after, a copy of your **2 most recent and consecutive check stubs showing Year to Date income.**

- ***If you receive child support or alimony,*** a copy of the court order showing how much you receive and if it is weekly, monthly, etc., or a copy of the check you receive, also stating if you receive weekly, monthly, etc.

- ***If you have been laid off from work,*** you must show date laid off and when you started receiving unemployment checks and a copy of how much you receive. You may also provide a copy of a 1099.

- ***If you are on Worker's Compensation***, you must provide proof of approval or denial of worker's compensation benefits (a copy of the approval/denial forms, a copy of the check, etc.)

- ***If you are self-employed,*** you must submit a complete copy of your tax return for the previous year, including all Business Schedule forms.

- ***If you receive SNAP benefits (Supplemental Nutritional Assistance Program formerly known as Food Stamps) or other governmental support***, you must provide proof of the amount (a copy from the Dept of Human Services, a copy of your approval letter, etc.)

Proof of Residency Requirements:

Please provide proof of your address (a copy of your Driver's License, other form of ID, utility bill, etc.)

If you do not send in proof of all income/assets listed and complete all other requested information on the application, you will be denied financial assistance. DO NOT LEAVE ANY QUESTIONS BLANK. If you have any questions please call (931) 359-6241 and ask to speak with a Financial Counselor.

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