**Financial Assistance Application**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To receive healthcare at a reduced cost to you, you must cooperate fully with our need for accurate and detailed financial information, including the timely production of necessary documentation. The intent of the Erlanger charity policy is to establish a fair and equitable system for determining hospital charity. General guidelines are established, allowing for evaluation of unique financial circumstances. In order for you or your family member to be considered under this program,proof of income must be submitted with the Financial Assistance Application **(Note: if patient is a minor/dependent, any of the following will apply to parent/guardian)** or letter from a third-party source (shelter, mission, group home, etc.) confirming financial status.

The following list are documents which may be considered as proof of income:

* Most recent tax return (Form 1040 or IRS letter stating no return on file for latest tax year)
* Statement of earnings from one of the following sources (which must be from same time period as bank statement provided):
  + Most recent paystubs (must span 4 weeks or 30-day period)
  + Social Security Statement of earnings
  + SSI Disability Benefit letter
  + Unemployment vouchers (must span 4 weeks or 30-day period)
* 3-5 Months of most recent bank statements

The application must be returned to Erlanger Behavioral Health Hospital at the below listed address:

**Patient Financial Services**

**804 North Holtzclaw Ave**

**Chattanooga, TN 37404**

Incomplete or fraudulent applications will be denied. Fraudulent information may also lead to revocation of charity assistance if discovered after it has been granted. In completing this financial assistance, I hereby affirm that the above statements are correct and complete. I give my consent to further verification by Erlanger Behavioral Health Hospital or its agents.

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Patient Signature or Power of Attorney Date

Relationship if other than the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sincerely, Financial Counselor