MISSION HEALTH

FINANCIAL ASSISTANCE APPLICATION
Hospital Name:
Account Number:
Date of Service:
Patient Name:
Patient Social Security Number:
Responsible Party Name:
Responsible Party Social Security Number:

SAMPLE FORM

Following your date of service, your financial assistance application will present all available information in the fields to the left for your review and verification. The sections below will be blank for you to complete and return along with required supporting documentation. Please contact us at [844-974-3800] with any questions about the financial assistance application process.

Dependents in Household-(This includes spouse, children under 18 and all others claimed on your tax return)

Name: **Age:**
(First, Middle and Last Name if different than Patient)

_____ _____
_____ _____
_____ _____

Employment (Patient/Responsible Party)
Employer Name: _____
Hourly Rate: _____ Hours Worked Per Week: _____
Current Gross Weekly, Monthly or Yearly Income (before taxes): _____
If unemployed, date last worked: _____

Spouse Employment
Employer Name: _____
Hourly Rate: _____ Hours Worked Per Week: _____
Current Gross Weekly, Monthly or Yearly Income (before taxes): _____
If unemployed, date last worked: _____

OTHER INCOME

	Patient	Spouse
Social Security		
Pension		
Unemployment		
Worker's Compensation		
VA Benefits		
Rental Income		
Stocks, Bonds, 401K		
Dividend/Interest		
Child Support		
Alimony		
Other		

Have you applied for Medicaid or any other State/County Assistance? Yes/No ☐
If yes and known, Case Number: _____ Date Applied: _____

I, the undersigned, certify that I am eligible for financial assistance because I am the person responsible for payment of amounts that may be due because of services provided. I further certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application and to assist in determining whether I am qualified for financial assistance. I understand that falsification of information or failure to complete all fields submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to help pay this hospital bill prior to completing this application.

Signature: _____ Date: _____

MISSION HEALTH

Mission Health
PO Box 291569
NASHVILLE, TN 37229-1569

Required Supporting Documentation

It is necessary for you to provide your Federal Tax Return for supporting documentation. If you did not file a tax return, please attach any two of the documents listed below.

* State Income Tax Return
* Employer Pay Stubs
* Written documentation from income sources
* Copies of all bank statements for the past three (3) months

If you are covered by Medicare, it is necessary for you to provide us with your latest Federal Tax Return for supporting documentation. If you did not file a tax return, please attach any of the two documents listed below.

* Supporting W-2
* Supporting 1099s
* Most recent bank and broker statements
* Qualified Medicare Benefits

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.