Application for Financial Assistance

Mandatory fields are denoted by red asterisk: *

Unity Medical Center
481 Interstate Dr.
Manchester, TN 37355
Phone: 931-450-1117
Fax: 931-450-1973

Personal Information:

* **Patient Name:** ______ **Patient Account #:** ______ ***Date:** ______

* **Address:** ______
Street City State Zip

* **Rent/ Own:** ______ ***Payment:** ______ **Value:** ______

* **Social Security Number:** ______ * **Date of Birth:** ______
Month/Date/Year

* **Phone:** ______ **Employed:** ☐ **Unemployed:** ☐

Employer: ______
Name/Address/Telephone Number

Spouse Name: ______ **Social Security #:** ______ **Birth Date:** ______
Month/Date/Year

For Minors Only:

Patient's Father: ______ **Social Security #:** ______ **Birth Date:** ______
Month/Date/Year

Patient's Mother: ______ **Social Security #:** ______ **Birth Date:** ______
Month/Date/Year

A. Wages (please provide wages for each member of your household)

Patient Wages:

$	$	$	
Annual Salary	Hourly Rate	Monthly Salary	# of hours/week

Other Wages:

Name	Relationship	Employer

$	$	$	
Annual Salary	Hourly Rate	Monthly Salary	# of hours/week

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Other Wages:

Name	Relationship	Employer

Annual Salary	Hourly Rate	Monthly Salary	# of hours/week
$	$	$	

Other Wages:

Name	Relationship	Employer

Annual Salary	Hourly Rate	Monthly Salary	# of hours/week
$	$	$	

B. Other Resources (please provide the total amount of other resources available to you, including savings accounts, checking accounts, stocks, bonds, trust funds, etc.)

Amount	Source
$	

Please provide the amount of yearly income you receive from these other resources, including interest income, dividends, rental income, etc.

$

Yearly Salary

*

C. Household Members:

Please provide the number of persons in the patient's household:

*

D. Income Verification: Please provide the following documents to verify household income:

- IRS Form W-2
- Paycheck Remittance
- Tax Return
- Bank Statements
- Employer Verification
- Proof of Participation in Governmental Assistance programs such as food stamps, SNAP, AFDC or Medicaid
- Social Security or Unemployment Compensation Determination Letters
- Other

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

Declaration:

I understand Unity Medical Center ("Hospital") may verify the financial information contained in this Financial Assistance application and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize Hospital to request reports from credit reporting agencies and the Social Security Administration. I certify that this information is true to the best of my knowledge and I am aware that falsification of information may result in denial of assistance.

*

Signature Date

Hospital Representative Title Date