Ballad Health Application for Financial Assistance

Application Date: ______________

Patient's Name:____________________________________Social Security #:___________________DOB:_________Guarantor #: ______________

Account Number(s)_________________________,_________________________,_________________________, _________________________

Please provide all documentation listed below that applies. Sign and return to the address listed below. Documentation should include all family members in the household. *Attach the parent's income information if the patient is a full-time student and claimed on their parent's tax returns.

Required Documentation **(*DO NOT send originals* Please use black ink)**

- ☐ If you are employed, you will need to provide your W-2 and your last 3 month's pay stubs. If a W-2 and pay stubs are not available, you will need a letter from your employer on company letterhead.
- ☐ If you are unemployed and have no income, you must provide verification of your circumstances. Verification can be provided by a written statement from your physician, pastor, or attorney on letterhead. If you have a pending Supplement or Social Security Claim, please provide a letter from Social Security or your disability attorney.
- ☐ Last two years of Federal Tax Returns are required. If you are self-employed, this includes the schedule C.
- ☐ If you have not filed taxes in either of the past two years, please complete and return Form 4506-T to the IRS to obtain verification of non-filing, or visit the www.irs.gov website and request a transcript of non-filing. If you do not have internet service, you can mail or fax your 4506-T form to the address/phone number listed on the 2nd page for your state. For additional information please visit www.irs.gov.
- ☐ If you are drawing Social Security, SSI, Social Security Disability, Veteran or a Military Pension, you will need to provide verification of that income. If your minor children also receive a check, you must provide verification of their income as well.
- ☐ If you are drawing a retirement check, pension, annuity, short/long term disability, or worker's compensation, you will need to provide verification of that income.
- ☐ If you receive Food Stamps or AFDC (Aid for Dependent Children) you will need to provide a Certification letter.
- ☐ If you receive child support, alimony, or receive any assistance from your children's other parent (not living in the household), you will need to provide verification of that income source.
- ☐ If you are unemployed and drawing unemployment benefits, you will need to provide verification of the amount you receive. Verification can be unemployment benefit approval letter.
- ☐ If you are separated and/or going through a divorce you will need to provide legal proof of the separation; otherwise we will need both spouse's information.
- ☐ If your monthly expenses exceed your income, you will need to provide verification of how your monthly expenses are being satisfied. Verification can be letters of support from your family, friends, church, or other supporting organizations.
- ☐ Proof of cash value of Stocks, Bonds, CD's and Mutual Funds
- ☐ List all assets such as real estate, rental income, investment property, vehicles, boat, recreational vehicles, etc.
- ☐ If you own your home, you must provide copies of your most recent mortgage statement.
- ☐ Provide the most recent copy of your checking, savings, and (HSA) Health Savings Account. Include all pages of the statements.
- ☐ Copy of police report if you were involved in motor vehicle accident.
- ☐ Proof of third-party benefits exhausted.
- ☐ Medicaid approval or denial letter, if applicable.

Determining Eligibility

Ballad Health will determine financial assistance eligibility based primarily on Federal Poverty Income Guidelines. Approved applications will be used for Ballad Health accounts **ONLY.**

Continued Collections During Your Application Process

Please note that extraordinary collection actions on your account will be suspended during the consideration of a completed charity application. You will have 30 days from the date of the financial application to provide all supporting documentation or your account will be released for billing. If the supporting documentation is not provided with the financial statement and/or there is any falsification of any portion of the application, your application will be denied. Ballad Health has the right to reverse its decision concerning financial assistance when information is presented that indicates the patient/guarantor has or had the ability to pay for their services and financial assistance should not have been approved.

If you need assistance in completing this application, please visit the Single Billing Office, a Ballad Health facility/office or call 423-408-7400 or 888-288-5174, Monday – Friday, 8:00 a.m. to 4:30 p.m.

Mailing Address: Ballad Health
PO Box 2308
Johnson City,TN 37605

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Patient/Responsible Party Information (Please Print)

Patient Full Name	Date of Birth	Responsible Party (Spouse/Guardian/Guarantor)
Address (Physical Address)	Zip Code	City

Social Security No.	Home Telephone No.	Married ( ) Single ( ) Separated ( ) Divorced ( )

Own your home ( ) Rent ( ) Landlord's Name	Mo. Pmt	Approximate Value $

Employer (Name & Address) q Unemployed	Tel. #	Emp. Since	Mo. Income

Does Employer offer Medical Insurance? Yes ( ) No ( )
If offered and you do not subscribe, please indicate reason.

Are you on disability? No ( ) Yes ( ) How long?______________________________Are you a veteran? No ( ) Yes ( ) Branch_________________

Are any of the accounts listed due to a motor vehicle accident or any other personal injury? Yes ( ) No ( )
If yes, please provide the following info: Insurance Company or Attorney name;
Policy Number:__________________ Insurance Company:_______________ Attorney Name _________________Phone Number:_____________________

Spouse Information

Name:	Social Security No.	Does employer offer Medical Insurance? No ( ) Yes( ) If offered and you do not subscribe, please indicate reason,

Employer (Name and Address) q Unemployed	Tel. #	Emp. Since	Mo. Income

Dependents

Name	Date of Birth	Relationship	Name	Date of Birth	Relationship

Monthly Expenses	
Mortgage/Rent Pmt	$
Electric	$
Water	$
Telephone/Cell	$
Food Expense	$
Clothing	$
Home-Auto Ins	$
Life/Burial Ins	$
Hospital Pmt	$
Alimony/Support	$
Child Care	$

Monthly Expenses	
Auto Payment (s)	$
Bank Loan	$
Finance Co	$
Credit Cards	$
Medications	$
Cable TV	$
Home Ins	$
Health Ins	$
Physician Pmt	$
Other (Specify)	$
Other (Specify)	$
Total Mo Expenses:	**$**

Total Number in Household:	

Monthly Income	
Patient	$
Spouse	$
Dependent (s)	$
Social Security	$
Disability	$
Unemployment	$
Child Support	$
Rental Income	$
Public Assistance	$
Alimony	$
Food Stamps	$
Worker's Compensation	$
Military Allotments	$
Dividends, Interest	$
Pensions	$
Other Income	$
Total Income	**$**

Assets	
Checking Account	$
Savings Account	$
Health Savings Account	$
Certificates of Deposit	$
IRAs	$
Land/Property other than home living in	$
Other	$

Additional Assets	Estimated Value
Auto #1	$
Auto #2	$
Motorcycle #1	$
Motorcycle #2	$
Boat	$
Recreational Vehicle	$

Applicant's statement: I do hereby certify that the information on this form is correct and true to the best of my knowledge & that no pertinent items of information have been concealed or omitted from this application. I also understand that Ballad Health has the right to reverse its decision concerning charity discounts when discovery of information is made that indicates the patient/guardian/guarantor has or had the ability to pay for their services. I am giving Ballad Health permission to access my credit file and to provide my financial information to those companies contracted by Ballad Health for the purpose of determining eligibility for any programs for which I may qualify.

Patient/Guardian/Guarantor Signature ____ **Date** _______________

Comments:

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