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FINANCIAL HARDSHIP APPLICATION

If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is your responsibility to inform us *prior to your appointment or procedure*. A completed Financial Hardship Application and support documentation are required. All information relating to financial hardship requests will be kept confidential.

PERSONAL INFORMATION

Last Name: _____ First Name: _____Middle Name: _____

Date of Birth: _____ Social Security #: _____

Number of Family Members Living in Household? _____ Date(s) of Service: _____

Home Address: _____ City: _____State: ___ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Phone: _____ Occupation: _____

Address: _____ City: _____State: ___ Zip: _____

If unemployed, how long? _____

Employment Status of Family Members Living in Household:

Family Member: _____ Employer: _____

Address: _____ City: _____State: ___ Zip: _____

Family Member: _____ Employer: _____

Address: _____ City: _____State: ___ Zip: _____

Family Member: _____ Employer: _____

Address: _____ City: _____State: ___ Zip: _____

Family Member: _____ Employer: _____

Address: _____ City: _____State: ___ Zip: _____

Family Member: _____ Employer: _____

Address: _____ City: _____State: ___ Zip: _____

Family Member: _____ Employer: _____

Address: _____ City: _____State: ___ Zip: _____

FINANCIAL DISCLOSURE STATEMENT

Pain Management of Middle Tennessee uses the most current United States Department of Health and Human Services Poverty Guidelines in assessing financial need. Please complete the following:

FAMILY INCOME SOURCES

Please put a check beside the source of your family income:

_____Patient _____Spouse _____Children _____Other: _____

Gross Family Salary	$_____
Gross Public Assistance Benefits	$_____
Gross Unemployment Benefits	$_____
Gross Social Security Benefits	$_____
Gross Workers Compensation Loss Wages	$_____
Gross Child Support	$_____
Gross Alimony	$_____
Other (rent income, etc.): _____	$_____
TOTAL FAMILY INCOME PER MONTH	$_____

FAMILY INCOME SOURCE DOCUMENTATION

Please provide a copy of the following documentation with your application, where applicable:

_____Most recent Internal Revenue Service Form 1040 (must be signed)

_____For the past 30 days, paycheck stubs for all employed family members living in household

_____For the past 30 days, Public Assistance Benefits check stubs

_____For the past 30 days, Unemployment Benefits check stubs

_____For the past 30 days, Social Security Benefits check stubs

_____For the past 30 days, Workers Compensation Loss Wages check stubs

_____For the past 30 days, Child Support check stubs

_____For the past 30 days, Alimony check stubs

_____For the past 30 days, Other income check stubs or proof of payment

_____Denial Letter from any Public Benefit Program

By signing this document, I hereby acknowledge that the information that I have provided is true and accurate to the best of my knowledge. I authorize Pain Management of Middle Tennessee to verify any information contained in this document for the sole purpose of assessing financial need. Any signed copy of this document is as valid as the original.

Name of Patient: _____ Date of Birth: _____

Signature of Patient / Personal Representative: _____Date: _____

Name of Personal Representative (if applicable): _____ Relationship to Patient: _____