MUST BE RETURNED WITHIN 30 DAYS
ALL INFORMATION MUST BE COMPLETED FOR APPLICATION TO BE PROCESSED.

INCOME AMOUNT RECEIVED MONTHLY:

Wages	$	Self-Employment Earnings	$
Public Assistance	$	Social Security	$
Unemployment	$	Workers' Compensation	$
Alimony	$	Child Support	$
Retirement Benefits	$	Incomes from Dividends	$
Food Stamps	$	Other	$

OTHER ASSETS

Property other than home: ❑ Yes ❑ No Value: __________ Inheritance Amt: __________
IRA / 401K Amt: __________ CDs / Bonds: __________
Other Assets: __________

MONTHLY EXPENSES:

Rent / Mortgage: __________ Cell Phone: __________ Groceries: __________
Water: __________ Health Insurance: __________ Alimony: __________
Electric / Gas: __________ Vehicle Insurance: __________ Child Support: __________
Satellite / Cable: __________ Internet: __________ Credit Card: __________
Home Phone: __________ Medications: __________ Credit Card: __________
Total Medical Bills Outstanding: __________ Credit Card: __________

Vehicle Make / Model: __________ Vehicle Make / Model: __________
Monthly Payment: __________ Monthly Payment: __________
Recreational Vehicle Make / Model: __________ Recreational Vehicle Make / Model: __________
Monthly Payment: __________ Monthly Payment: __________

Please use the following space to indicate any special circumstances that we may need to know to process your Financial Application. This space may also be used to indicate if there is no income in the household, how you are meeting your financial obligation.

____
____
____
____
____
____
____
____

Form PFS-03 (Rev. 1/13)

Application For FINANCIAL ASSISTANCE

COOKEVILLE REGIONAL MEDICAL CENTER
The Proven Choice

COOKEVILLE REGIONAL MEDICAL CENTER

Application for Financial Assistance

I hereby request that Cookeville Regional Medical Center make a written determination of my eligibility for the Financial Assistance Program. I understand that the information which I submit concerning my annual income and family size is subject to verification by Cookeville Regional Medical Center and their financial guidelines. I also understand that if the information I submit is determined to be false, such determination may result in a denial of providing financial assistance and I will be liable for all charges incurred. This determination is based upon the income reported and covers only hospital charges and does not extend to any professional fees outside this facility.

I acknowledge that CRMC expects all applicants to exhaust all other payment sources as a condition for approval. Therefore, I may be required to apply for such resources; i.e. Medicaid or Disability before seeking financial assistance. I understand that while waiting for the determination to be made regarding my financial assistance, CRMC requires that good faith payments be made monthly towards my outstanding balances. This application is good for a period of six to twelve months depending on income source.

Signature of Guarantor ______________________ Date Signed ______________

Please complete and sign the yellow highlighted areas on the application. You will also need to send us copies of the information that has been checked below. We have enclosed a self-addressed stamped envelope for your convenience. **You must return this information to us within 30 days for your application to be considered for review.**

- ❑ Last two months bank statement
- ❑ Copy of Social Security or Disability Check or benefits letter (unless stated on your Bank Statement)
- ❑ Copy of Retirement or Pension check (unless stated on your Bank Statement)
- ❑ Last three pay stubs for all working members in the household including unemployment benefits
- ❑ Child Support and/or Alimony income
- ❑ W2 from employer for last calendar year
- ❑ Income tax return for last year
- ❑ Copy of Food Stamp Letter
- ❑ Signed statement with phone number of anyone helping you financially
- ❑ Document verifying you have applied for Disability
- ❑ Doctor's statement for Release from Work
- ❑ Copy of Denial Letter from Tenncare
- ❑ Other: ______________________

If you cannot provide this information please contact us immediately to see if an alternate form of income verification can be used. Please note that it may take up to 150 days to process your application. If you have any questions or comments, please do not hesitate to call us at (931) 783-2360.

Hospital Representative ______________________ Date Signed ______________

APPROVAL REQUIRED: PLEASE INITIAL

$1.00 - $2500.00	Collections Manager	❑ Approved	❑ Denied	Initial ________	Date ________
$2,501.00 - $4999.99	Business Office Director	❑ Approved	❑ Denied	Initial ________	Date ________
> $5000.00	Administrator	❑ Approved	❑ Denied	Initial ________	Date ________

If denied, reasons(s) ______________________________________

DEMOGRAPHIC INFORMATION

Guarantor Name: ______________________ Date of Birth __________ Age: ________

Guarantor SSN: ______________________

Guarantor Address: ______________________________________

Guarantor Home Phone: ______________________ Work Phone: ______________________

Employed: ❑ Yes ❑ No ❑ Full-Time Hrs: ________ ❑ Part-Time Hrs: ________

Employer Name: ______________________ Occupation: ______________________

How long employed: ______________________

If not employed please indicate time frame: ______________

Disabled: ❑ Yes ❑ No Are you receiving disability benefits: ❑ Yes ❑ No

Have you applied for disability? ❑ Yes ❑ No Date: ______________

Do you have health insurance: ❑ Yes ❑ No

Please indicate what type of insurance you have or why you do not currently have insurance: ______________________

SPOUSE INFORMATION

Name: ______________________ SSN: ______________________

Employed: ❑ Yes ❑ No D.O.B.: ______________ Age: ________

Employer Name: ______________________ Occupation: ______________________

How long employed: ______________________

If not employed please indicate time frame: ______________

Disabled: ❑ Yes ❑ No Are you receiving disability benefits: ❑ Yes ❑ No

Have you applied for disability? ❑ Yes ❑ No Date: ______________

Do you have health insurance: ❑ Yes ❑ No

Please indicate what type of insurance you have or why you do not currently have insurance: ______________________

Please indicate anyone living in the home with you:

Name	D.O.B.	Place of employment/income