THE UNIVERSITY OF TENNESSEE MEDICAL CENTER
Wisdom for Your Life.

UTMC Financial Assistance Application

You may qualify for FREE or DISCOUNTED care at UT Medical Center. If you would like to be considered for Financial Assistance through UTMC, please complete the application located on the back of this checklist. It is important that you complete the application in its entirety and return all necessary documentation within 240 days following your first billing statement to help UTMC determine your eligibility. Submit your application to UTMC in person, by mail, email, or fax to:

Mail: **UT Medical Center Financial Assistance Program**
PO Box 32749
Knoxville, TN 37930-2749

Fax: **865-251-4413**
Attn: UT Medical Center Financial Assistance Program

Email**: BOCustomerservice@utmck.edu**
Subject: Financial Assistance Application

Please call a UTMC Financial Counselor at 865-251-4400 if you have any questions.

The documents listed below will help us in evaluating your application. Please complete this form and submit all required documentation listed below within 240 days following the first billing statement and submit to UTMC.

Proof of Income:

- Must provide one (1):
  - ✓ Most Recent Federal Tax Return
  - ✓ Recent W-2's or 1099's
  - ✓ Two (2) most recent pay stubs
  - ✓ Written income verification from employer if paid in cash
  - ✓ Social Security Benefits letter(s) if no income
  - ✓ Documentation of any other source of income: Pension, Unemployment, Alimony, Child Support, VA benefits, etc. if applicable.
  - ✓ Any other reasonable form of income verification acceptable by UTMC
- Must provide:
  - ✓ Most recent Bank Statement

Other Documentation, if applicable:

- ✓ Copy of divorce decree
- ✓ Declination or denial of insurance coverage

Explanation of any missing documentation:

_____

_____

_____

UTMC FINANCIAL ASSISTANCE APPLICATION

SECTION 1 - PATIENT (APPLICANT) INFORMATION

Account Numbers: _____

Name		Date of Birth	Address - street, city, state, zip			
SSN		Home Phone	Cell Phone		Email Address	
Employed? Y or N	Date of Hire:	Date of Unemployment:	Self-Employed? Y or N	Student? Y or N	Disabled? Y or N	Retired? Y or N
Employer Name		Employer Phone	Employer Address			

SECTION 2 - SPOUSE or GUARANTOR (Please indicate relationship to patient): _____

Name			Address - street, city, state, zip			
Home Phone			Cell Phone			
Employed? Y or N	Date of Hire:	Date of Unemployment:	Self-Employed? Y or N	Student? Y or N	Disabled? Y or N	Retired? Y or N
Employer Name		Employer Phone	Employer Address			

SECTION 3 - HEALTH INSURANCE ELIGIBILITY:				SECTION 4 - HOSPITAL PRESUMPTIVE CRITERIA
Was your care Accident Related? Y or N	Have you applied for Medicaid? Y or N	Do you have COBRA coverage? Y or N		Is the patient currently homeless? Y or N
Were you a Victim of an Alleged Crime? Y or N	Do you have Insurance? Y or N	Insurance Carrier:	Effective Date:	Is the patient eligible for Medicaid? Y or N
Was your care due to a Work Related Injury? Y or N	Do you have Secondary Insurance? Y or N	Insurance Carrier:	Effective Date:	Is the patient mentally incapacitated with no one to act on their behalf? Y or N
Do you receive State Public Services such as TANF, Basic Food, or WIC? Y or N	Have you applied for Insurance? Y or N	Insurance Applied for:	Application Date:	Is the patient deceased with no estate? Y or N

SECTION 5 - FAMILY & HOUSEHOLD INFORMATION

Number of people living in the home:		Number of legal dependents:		Age of legal dependents:			

SECTION 6 - IF YOU ARE UNINSURED AND ANSWERED YES TO ANY PART OF SECTION 4, THIS SECTION IS NOT REQUIRED.

SECTION 6A - MONTHLY GROSS INCOME			SECTION 6B - ASSETS			SECTION 6C - MONTHLY EXPENSE	
Income:	Patient/ Applicant:	Spouse/ Guarantor:	Assets:		Value:	If you are uninsured and your monthly income is less than $2,000, this section is not required	
Wages:	$	$	Checking Account:	Y or N	$	Housing:	$
Self Employment:	$	$	Saving Account(s):	Y or N	$	Utilities:	$
Social Security:	$	$	Stocks/Bonds/CDs:	Y or N	$	Food:	$
Pension or Retirement:	$	$	Trust(s):	Y or N	$	Transportation:	$
Disability:	$	$	Health Savings or Flex Spend Accts:	Y or N	$	Medical Expenses:	$
Unemployment:	$	$	401K:	Y or N	$	Child Care:	$
Workers' Compensation:	$	$	Vehicle:	Y or N	$	Loans:	$
Temp Assistance:	$	$	Other vehicles:	Y or N	$	Loans:	$
Child Support:	$	$	Real Estate/Property:	Y or N	$	Mortgage:	$
Alimony or Spousal Support:	$	$	Owner of a Business:	Y or N	$	Mortgage:	$
Other Income:	$	$	Other Assets:	Y or N	$	Other Expenses:	$
Total Monthly Income:	$	$	Total Asset Value:	$		Total Monthly Expenses:	$

I certify that everything in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified by UTMC and I authorize UTMC to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide false information in this application, I will be ineligible for financial assistance.

Applicant Signature: _____ Date: ____/____/____

Approved: Y N Reason: _____UT Authorized Signature:_____ Date: ____/____/____