Dear Patient/Responsible Party.

We are providing this application, because you may qualify for our ***Financial Assistance Program.***

The attached form only applies to hospital bills, and does not include any other medical bills you may have; such as physician, radiology, ambulance, etc.

In order to be considered for a full or partial assistance, you **must** complete the Financial Assistance Application. The responsible party **must sign** the bottom, and return the completed application within fourteen (14) days of receipt.

Inpatient Visits: If you were admitted into the hospital as an inpatient, it is necessary for you to provide us with **your latest Federal Tax Return** for supporting documentation. If you did not file a tax return, please indicate and attach any two of the documents listed below.

State Income Tax Return
Employer Pay Stubs
Written documentation from income sources
Copies of all bank statements for the past three months

Medicare Patients: If you are covered by Medicare, it is necessary for you to provide us with **your latest Federal Tax Return** for supporting documentation. If you did not file a tax return, please indicate and attach any of the documents listed below.

Supporting W-2
Supporting 1099's
Most recent bank and broker statements
Qualified Medicare Benefits

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.

Please allow ten (10) business days for our review process. We will notify you of our charity determination by letter. If you have any questions or concerns, please feel free to contact Customer Service at any time.

Remember if you return this form your bill may be included in our Financial Assistance Program

Mail to:

Parallon
P.O. Box 290669
Nashville, TN 37229-0669

FINANCIAL ASSISTANCE APPLICATION

Hospital Name_____ Account Number_____
Patient Name_____ Social Security Number_____
Responsible Party Name_____ Social Security Number_____

Dependents in Household

(This includes spouse, children under 18 and all others claimed on your tax return)

Name (First, Middle and Last Name if different than Patient) Age

_____ ____
_____ ____
_____ ____

Employment (Patient/Responsible Party)

Employer Name_____ Hourly Rate_____ Hours Worked Per Week_____
Current Gross Weekly, Monthly or Yearly Income (Before Taxes)_____
If unemployed, date last worked_____

Spouse Employment

Employer Name_____ Hourly Rate_____ Hours Worked Per Week_____
Current Gross Weekly, Monthly or Yearly Income (Before Taxes)_____
If unemployed, date last worked_____

Other Income

	Patient	Spouse
Social Security		
Pension		
Unemployment		
Worker's Compensation		
VA Benefits		
Rental Income		
Stocks, Bond, 401K		
Dividend/Interest		
Child Support		
Alimony		
Other		

Have you applied for Medicaid or any other State/County Assistance? _____
If yes and known, Case Number_____ Date Applied_____

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. Additionally, I understand that in accordance with Florida Statutes §817.50, providing false information to defraud a hospital for the purposes of obtaining goods or services is a misdemeanor in the second degree. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to help pay this hospital bill prior to completing this application.

Signature_____ Date_____

Witness _____ Date_____