WILLIAMSON
HEALTH

FINANCIAL ASSISTANCE APPLICATION

Dear Williamson Health Patient,

This packet includes:

1. Application packet instructions
2. Supporting documentation requirements
3. Financial aid application

Applications are processed upon the information provided. Please allow up to two (2) weeks to process your application. Eligibility is based on the Federal Poverty Income Guidelines. Collection will continue on your account until the required documentation is returned to Williamson Health. If the supporting documentation is not submitted with the application and/or falsification of any portion of the application is identified, your application will be denied. Williamson Health reserves the right to reverse financial assistance when information is presented indicating the patient/guarantor has the ability to pay for services and financial assistance should not have been approved.

All pertinent supporting documentation must be submitted to be considered for assistance. **Incomplete applications will be rejected, and payment in full will become due.** Once you've completed the application, please mail the entire packet to the address listed below.

Williamson Health
P.O. Box 681868
Franklin, TN 37068-1868

Contact info:

Last Name begins with A-G 615-435-5889
Last Name begins with H-O 615-435-5897
Last Name begins with P-Z 615-435-5893

***This program does not apply to all physicians or other professional fees billed separately from the hospital facility. It's your responsibility to contact your other providers to request financial assistance.**

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FINANCIAL ASSISTANCE CHECKLIST

SUPPORTING DOCUMENTATION: READ CAREFULLY

THE FOLLOWING **PROOF** OF INCOME/ASSETS THAT APPLY TO **YOU AND YOUR SPOUSE** AND ANY OTHER HOUSEHOLD DEPENDENT(S) IS REQUIRED

☐ **If you or your spouse are employed,** provide your 2 most recent and consecutive check stubs showing year to date gross income.

☐ **Submit all pages of your tax return** for the previous year, including all Business Schedule forms.

☐ **For those who draw Social Security,** provide award letter stating how much you receive for the current year. Social Security will send you a new one if needed, call 800-772-1213.

☐ **If you draw retirement/pension,** provide a check stub, benefit statement, or W2.

☐ **If you have no income, you must provide:**

- ☐ Two notarized letters: one from whoever is helping you with food, shelter, and other financial support with explanation and a second notarized letter from a non-family member who lives outside your home validating your financial situation.
- ☐ Provide a copy of your last tax return. A tax transcript from IRS.gov is accepted.
- ☐ If you are a full-time student, provide a copy of your current transcript.

☐ **Two months (60 days) current and consecutive bank statements** for all bank accounts (checking, savings, etc). All statements must include the account holders name and address and the bank name/logo for identification purposes. Give a brief explanation of any deposits over $500.00.

☐ **Two months (60 days) of statements for any investment accounts:** CDs, stocks, bonds, IRA, 401k, 403b, etc.

☐ **Two months (60 days) of statements for any payment apps:** PayPal, Cash App, Venmo, Square Inc., Google Pay, Meta Pay, etc.

☐ **If you have applied for social security disability** but have not yet received a decision or received a denial, include a copy of the most recent disability correspondence (application confirmation, letter from lawyer, social security office letter, disability determination letter, etc.)

☐ **If you are receiving short term or long term disability,** provide your 2 most recent check stubs or a letter from your employer stating how much you receive and for how long.

☐ **If you have been laid off from work,** provide unemployment award letter.

☐ **If you are on worker's compensation,** you must provide proof of approval of worker's compensation benefits.

☐ **If you receive child support or alimony,** provide the court order showing how much you receive.

☐ **If you receive SNAP benefits (Supplemental Nutritional Assistance Program formerly known as Food Stamps) or other government support,** you must provide proof of the amount (a copy from the Department of Human Services).

☐ **Claiming dependents:** Proof of dependents listed on application, provide the dependent page from your taxes.

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REQUEST FOR FINANCIAL ASSISTANCE

I hereby request that Williamson Health, make a written determination of my eligibility for financial assistance for services rendered. I understand that the information that I submit is subject to verification by Williamson Health. I also understand that if the information that I submit is determined to be false, that my request for financial assistance will be denied and the charges for services rendered will be my full responsibility.

1. FULL NAME: _____

2. ADDRESS: _____ CITY: _____

   ZIP: _____ PHONE #: _____

3. SOCIAL SECURITY #: _____

4. MARITAL STATUS *(please check the appropriate box)*
   ☐ Married ☐ Divorced ☐ Single ☐ Widow/Widower ☐ Legally Separated*

5. APPLICANT'S EMPLOYMENT STATUS *(please check the appropriate box)*
   ☐ Employed ☐ Full Time ☐ Employed Part Time ☐ Retired ☐ Disabled ☐ Not Employed

6. EMPLOYER: _____ YEARS EMP.: _____
   (If less than 1 year, please list previous employer and employment dates below)

   PREVIOUS EMPLOYER: _____ DATES: _____

7. SPOUSE'S EMPLOYMENT STATUS (please check the appropriate box)
   ☐ Employed Full Time ☐ Employed Part Time ☐ Retired ☐ Disabled ☐ Not Employed

8. SPOUSE'S EMPLOYER: _____ YEARS EMP.: _____
   (If less than 1 year, please list previous employer and employment dates below)

   PREVIOUS EMPLOYER: _____ DATES: _____

9. INSURANCE COMPANY NAME: _____

10. ARE ANY ACCOUNTS THE RESULT OF AN ACCIDENT THAT MAY BE COVERED BY AUTO INSURANCE, WORKER'S COMPENSATION, OR LIABILITY? ☐ YES ☐ NO
    (If the answer is YES, you must contact our office so we can file the insurance before those accounts can be considered for financial assistance.)

11. ARE YOU A US CITIZEN OR LEGAL IMMIGRANT? ☐ YES ☐ NO
    (Documentation required to show proof of Legal Immigrant Status)

12. FAMILY INFORMATION: *(List all dependents including yourself that live in your household.)*

	NAME	DATE OF BIRTH	RELATION	AGE
A)				
B)				
C)				
D)				
E)				
F)				

13. INCOME: *Check all that apply and include the monthly amount.*

PROOF OF INCOME IS REQUIRED — see attached page for acceptable proof of income.

Source	Amount	Source	Amount
☐ Wage	$_____	☐ Alimony/Child Support	$_____
☐ Social Security	$_____	☐ Food Stamps	$_____
☐ Unemployment	$_____	☐ Rental Income	$_____
☐ Pension	$_____	☐ Other (please explain)	$_____

14. ASSETS: *Please list all that apply for the entire household.*

Liquid Assets

Checking Account Balance(s) $ _____

Savings Account Balance(s) $ _____

CDs/Bonds/Stocks/IRAs, etc. (Total balances) $ _____

Auto/Truck Assets

Make/Model/Year _____ Estimated Value $ _____ Loan Balance$ _____

Make/Model/Year _____ Estimated Value $ _____ Loan Balance$ _____

Property Assets

Home (residence): Fair Market Value $ _____ Mortgage Balance: _____

Other Property:
(Vacation, rental, etc.) Fair Market Value $ _____ Mortgage Balance: _____

Other Assets

Other (ATVs, Boats, Motorcycles, etc.) (List approximate value) $ _____

15. EXPENSES: *Please list the monthly amounts below.*

Please also list, on the back of the application, any other household or medical expenses. You may use a separate sheet of paper if necessary.

Rent/Mortgage $ _____ Auto Loan $ _____

Credit Cards $ _____ Other Loan $ _____

If all information requested is not accurate or included, your application will be denied.

I hereby do affirm that the information contained in this application is accurate and I authorize Williamson Health to use information on my credit report in their process of determining my eligibility for their Financial Assistance Program.

SIGNATURE _____ **DATE** _____