HARDIN HMC MEDICAL CENTER

935 Wayne Road
Savannah, TN 38372
(731) 926-8136
Fax: (731) 926-8160

Indigent Care Application

Attached is an Indigent Care Application to apply for assistance on your account here at Hardin Medical Center. You **MUST** complete this application in order to be considered for **Financial Aid** on your account. Please complete the form and attach any documents that you or **ANYONE** in the **HOUSEHOLD** have showing **household income** (Disability, Social Security, Complete Income Tax Return, Food Stamp Letter, Unemployment, Last 4 Check Stubs, 3 Most Recent Bank Statements (all pages), Letter stating you have applied for Disability/Social Security ect.). We **MUST** have proof of how you are **"living" (**if no income, you must have a letter of support signed and dated by who is supporting you**).** If all documentation is returned to HMC in a timely matter and your income falls within the Federal Poverty Level and our current Indigent/Charity Care Policy, you may qualify for assistance. **If ALL documentation is not returned with the application, it will NOT be processed.** If you have any questions please feel free to contact me at **(731) 926-8136**.

******* *If you have already applied or been approved for Indigent Care/Charity you may want to check your current status to see if you need to reapply.*

Thanks,

Lisa White

Financial Counselor

Doctor _____ Doctor _____
Procedure / Test _____ Procedure / Test _____
Scheduled Date _____ Scheduled Date _____

Hardin Medical Center

Account(s): _____

Indigent Care Application

Patient's Name _____

Address _____

Date of Admission _____ Date of Discharge _____ Phone # _____

Fill in the chart for yourself and other family members/non family members living with you.

Name	Date Of Birth	Relation	Employer	Employed in the Past Year (if so where)	Student Y or N

I certify that to the best of my knowledge all of the information that I have provided is true and correct. I understand that if I have given false or misleading information, it could result in denial of my application and/or administrative finding resulting in the possibility of action against me by the facility. Also, I hereby authorize this hospital to disclose any of the above information to any State, Local, or Federal Agency responsible for this facility's Indigent Care Compliance.

_____ _____
Date of Request Applicant's Signature

NOTE: It is required that you provide proof of income for everyone in the household. Include all that apply to anyone in the home:

- ☐ ***Complete Income Tax Return***
- ☐ ***4 Most Recent Pay Stubs and/or Unemployment (Everyone in Household)*** **IF unemployed, as of when?** _____
- ☐ ***Proof of Social Security/Disability***
- ☐ ***3 Most Recent Bank Statements, all pages***
- ☐ ***Most Recent Utility Bill***
- ☐ ***Proof of Food Stamps - Amount $*** _____
- ☐ ***Letter of Support if currently supported by someone else***
- ☐ ***Other*** _____

FOR HOSPITAL USE ONLY

Notes regarding proof of income:

_____

_____

_____

Hospital Original Balance: _____

Hospital Current Balance: _____

Physician Balance: _____

☐ Self Pay ☐ Insured: _____

12 Month Income

Patient's Income		Family Size
Other Family Income		
Total Family Income		

Deposit(s) Required

$ _____ For _____

$ _____ For _____

$ _____ For _____

$ _____ For _____

Approved:

☐ Percentage _____

☐ Settlement _____ Approved By: _____ Date: _____

Revised 9-25-15