

FHN FINANCIAL ASSISTANCE APPLICATION

SECTION 1 - PATIENT (APPLICANT) INFORMATION												
Name			Date of Birth		Address - street, city, state, zip.							
SSN		Home Phone			Cell Phone		Email Address					
Employer Name		Employer Phone			Employer Address							
SECTION 2 - SPOUSE or PARTNER or GUARANTOR (Please indicate relationship to the patient here: _____)												
Name				Address - street, city, state, zip.								
Home Phone				Cell Phone								
Employer Name		Employer Phone			Employer Address							
SECTION 3 - HEALTH INSURANCE ELIGIBILITY:					SECTION 4 - HOSPITAL PRESUMPTIVE CRITERIA							
When FHN provided care was the patient:		Do you have Health Insurance?		Y/N	Insurance Carrier:		Effective Date:		Is the patient homeless?		Y/N	
An Illinois resident?		Y/N	Do you have secondary Ins?		Y/N	Insurance Carrier:		Effective Date:		Is the patient eligible for Medicaid?		Y/N
Involved in an accident?		Y/N	Have you applied for insurance?		Y/N	Insurance applied for:		Application Date:		Is the patient mentally incapacitated with no one to act on their behalf?		Y/N
The victim of an alleged crime?		Y/N	Is another person responsible for the patient's medical care as part of a legal dissolution or separation agreement?				Y/N		Is the patient deceased with no estate?		Y/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					
	Patient/Applicant		Spouse/Partner/Guarantor			Description		Value		If you are uninsured and your monthly income is less than \$2,000 this section is not required.		
Wages:	\$		\$		Checking Acct(s):	Bank/Institution	\$		Housing:	\$		
Self Employment:	\$		\$		Saving Acct(s):	Bank/Institution	\$		Utilities:	\$		
Social Security:	\$		\$		CD(s):	Bank/Institution	\$		Food:	\$		
Pension or Retirement:	\$		\$		Investments:	Bank/Institution	\$		Transportation:	\$		
Disability:	\$		\$		Health Savings or Flex Spend Acct(s)	Bank/Institution	\$		Medical Expenses:	\$		
Unemployment:	\$		\$		Auto:	Yr. Make & Model	\$		Child Care:	\$		
Workers' Compensation:	\$		\$		Auto:	Yr. Make & Model	\$		Loans:	\$		
Temp Assistance:	\$		\$		Other vehicles:	Yr. Type & Model	\$		Loans:	\$		
Child Support:	\$		\$		Real Estate:	Address	\$		Mortgage:	\$		
Alimony or Spousal Support:	\$		\$		Real Estate:	Address	\$		Mortgage:	\$		
Other Income:	\$		\$			Describe	\$		Other Expense:	\$		
Total Monthly Income:	\$		\$		Total Asset Value:		\$		Total Monthly Expense:	\$		

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this medical bill(s). I understand that the information provided may be verified by FHN and I authorize FHN to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the medical bill(s).

Print or Type Patient/Applicant Name _____

Print or Type Spouse/Partner/Guarantor _____

Signature of Patient/Applicant _____

Date _____

Signature of Spouse/Partner Guarantor _____

Date _____