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:

When FHN provided care was the patient:		Do you have Health Insurance?	Y/N	Insurance Carrier:	Effective Date:
An Illinois resident?	Y/N	Do you have secondary Ins?	Y/N	Insurance Carrier:	Effective Date:
Involved in an accident?	Y/N	Have you applied for insurance?	Y/N	Insurance applied for:	Application Date:
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	

SECTION 4 - HOSPITAL PRESUMPTIVE CRITERIA

Is the patient homeless?	Y/N
Is the patient eligible for Medicaid?	Y/N
Is the patient mentally incapacitated with no one to act on their behalf?	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