MACON COUNTY GENERAL HOSPITAL
P O BOX 378
LAFAYETTE TN 37083
615-666-2147

FINANCIAL ASSISTANCE APPLICATION

Patient Name: ____

Address: ____

____

Telephone: ________________________________ Cell: ____

DEPENDENT MEMBERS OF THE HOUSEHOLD (LIST YOURSELF FIRST)

Name(s)	Relationship	Date of Birth	Social Security #
___________________________	___________	____________	________________
___________________________	___________	____________	________________
___________________________	___________	____________	________________
___________________________	___________	____________	________________
___________________________	___________	____________	________________

EMPLOYMENT INFORMATION

(Please list you or anyone in your household – present or last employer)

Name	Employer	Position	Hire Date	End Date
___________________________	________________	___________	__________	__________
___________________________	________________	___________	__________	__________

CURRENT INCOME

Wage earner Name	Employer	Hours/Week	Amt. per month/week
___________________________	________________	_____________	__________________
___________________________	________________	_____________	__________________

OTHER INCOME $______________________ Please Explain ____________________________________

BANKING

Savings $___________________________ CD's $________________ Interest $________________

Stocks $_____________ Bonds $___________ Mutual Funds $___________ 401K/401B $____________

EXPENSES

Rent	$________________________	Cell Phone	$________________________
Heat/Electric/Gas	$________________________	Car Insurance	$________________________
Telephone	$________________________	Groceries	$________________________
Cable TV	$________________________	Credit Card/Cards	$________________________
Water	$_________________________	Food Stamps	$________________________

APPLICANT'S RIGHT AND RESPONSIBILITIES

1. I am applying for the Patient Financial Assistance from Macon County General Hospital.
2. I certify that all statements made by me on this application are true and correct, under penalty for false statement as provided by the Macon County General Hospital's Financial Assistance Policy.
3. I understand that I have a right to appeal if I am dissatisfied with the Hospital's decision on my application.
4. I agree that the information provided by me on this application must be verified and agree to provide documentation as requested.
5. I authorize Macon County General Hospital to conduct an investigation to establish my eligibility and give the hospital permission to obtain information necessary from, but not limited to the following sources: banks, credit unions and other financial institutions, employers, medical providers, landlord and other agencies such as The Department of Social Services, Department of Human Services, The Department of Labor, The Social Security and Veteran's Administrations and the Immigration and Naturalization.
6. I agree to complete the application process for any Third Party Benefits for which I may be eligible, including Health Insurance, Veterans Benefits, etc.

____ __________________________________

Signature of Applicant Date

____ __________________________________

Signature of Spouse/Interpreter/Witness Date

____ __________________________________

Signature of Financial Counselor Date

MAIL TO: Macon County General Hospital
P O Box 378
Lafayette, TN 37083
Att: Financial Counselor