FINANCIAL ASSISTANCE APPLICATION

SUBMIT IN PERSON, VIA PHONE OR MAIL TO: 1431 PERRONE WAY, FRANKLIN, TN 37069

Patient Name: (Last, First, MI) SSN # PID#

Patient Home Address Street City/State Zip Code

_____/_____/_____ _____-_____-_____ Marital Status: □ Married □ Single □Widowed □ Separated □ Divorced

Date of Birth (Month/Date/Year) Telephone Number

If Married, Spouse's Name: _____

Employer Information: Patient Employed? □Yes □ No Spouse Employed? □Yes □ No

Patient's Employer: _____ Spouse's Employer: _____

Income: **Please provide the income for each of the following person(s) in your household, where applicable:**

Patient: □Full Time □Part Time -Total Hours/Week= _____ $_____ □Hr □Wk □Bi-Wk □Month □Year

Spouse: □Full Time □Part Time -Total Hours/Week= _____ $_____ □Hr □Wk □Bi-Wk □Month □Year □ N/A

Complete this income section only if the patient is a Minor (18 years & under):

Patient's Mother or Legal Guardian: □Full Time □Part Time-Total Hours/Week= _____ $_____ □Hr □Wk □Bi-Wk □Month □Year

Patient's Father or Legal Guardian: □Full Time □Part Time-Total Hours/Week= _____ $_____ □Hr □Wk □Bi-Wk □Month □Year

Total Annual Household Income: $ _____ **Total Outstanding Medical Bills: $ _____**
(Copies of medical bill documentation required within 2 weeks)

Income Verification: Acceptable household income documentation is listed below. Please submit required copies within 2 weeks.

□Paycheck Remittance □Employer Verification □Workers Compensation or Unemployment Compensation Determination Letters
□IRS Form W-2 □Tax Return □Governmental Assistance (Food stamps, CDIC, Medicaid, TANF)
□Bank Statements □SS Determination Letters □**Other** _____ □**None (Written Attestation form required)**

Family Members: Provide the total number of people in the patient's household: _____
Please note: This number should only include the patient, patient's spouse, and the patients' dependents **unless the patient is a minor;** include the patient, the patient's parents and parents' dependents (if any).

I understand Touchstone Medical Imaging may verify the financial information contained in this Financial Assistance Application ("Application") in connection with Touchstone Medical Imaging's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance. I further understand that some physicians and providers may not be employees of Touchstone. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

_____ _____ _____
Signature of Patient or Responsible Party Printed Name Date

For Internal Use Only:

□ Application information obtained by Touchstone Employee in person or over the phone, **no patient signature required.**

_____
Touchstone Employee Name Printed Date

Notes Re: Income/Household Size: _____

Patient is verified Community Care Program? NO YES Program Name: _____