PATIENT FINANCIAL ASSISTANCE PROGRAM

APPLICATION

Tucson Medical Center recognizes that certain patients may require financial assistance in paying for healthcare services. The Patient Financial Assistance Program has been designed by the hospital in response to the needs of these patients.

Attached is the Patient Financial Assistance Application for you to complete and return to us by the date noted below. The information requested on the form will assist us in determining if you qualify for assistance. Please fill out the form as completely as possible and return with copies of the items that are checked below.

- ☐ **Most current W-2s and tax forms**
- ☐ **Last (3) paycheck stubs from employment**
- ☐ **Social Security Award Letter for current year**
- ☐ **Unemployment Compensation Benefit Letter**
- ☐ **Copy of Checking/Savings Account Statement(s)**
- ☐ **Rent Receipt/Lease/Mortgage Statement**
- ☐ **Room and Board/Support Letter**
- ☐ **Utility Bills**
- ☐ **Divorce Decree**

An incomplete application will be denied until it is fully completed.

If you have any questions regarding the financial application or documents needed, please contact Patient Financial Services at (520)324-1310.

TMC BUSINESS OFFICE

Enc: Application

PATIENT FINANCIAL ASSISTANCE PROGRAM

APPLICATION

PATIENT'S NAME			SEX	PATIENT ACCOUNT NUMBER	
GUARANTOR'S FIRST NAME	MI	LAST NAME	SEX	DOB	SOCIAL SECURITY#
ADDRESS OR PO BOX	CITY	STATE	ZIP		PHONE
SPOUSE'S FIRST NAME	MI	LAST NAME	SEX	DOB	SOCIAL SECURITY#
ADDRESS OR PO BOX	CITY	STATE	ZIP		PHONE

# IN HOUSEHOLD	PATIENT LIVES IN HOUSEHOLD	YES ☐ NO ☐
# OF CHILDREN UNDER 18 IN THE HOUSE HOLD	# OF DEPENDENT CHILDREN OVER 18	
# OF DEPENDENT CHILDREN OVER 18 THAT ARE FULL-TIME STUDENTS	# OF DEPENDENT CHILDREN THAT ARE DISABLED	

HOME	OWN ☐ RENT ☐	HOW LONG AT PRESENT ADDRESS

MONTHLY INCOME SOURCES	SPOUSE #1	SPOUSE #2	CHILDREN	TOTAL
Employment				
Social Security				
Industrial Comp				
Unemployment				
Pension/Retirement/Annuities				
ADC,GA, Food Stamps				
Other (rental income, child support, spousal, etc.)				
TOTAL GROSS INCOME				

MONTHLY EXPENSES		
HOME (RENT/MORTGAGE)	CAR	CAR
ELECTRIC BILL	GAS BILL	WATER BILL
PHONE BILL	TRASH BILL	CABLE BILL
CELL PHONE BILL	GROCERY	OTHER
CHECKING YES ☐ NO ☐	$ TOTAL AMOUNT	BANK NAME
SAVING YES ☐ NO ☐	$ TOTAL AMOUNT	BANK NAME

I CERTIFY THAT THE INFORMATION GIVEN HEREON IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT DELIBERATE FALSIFICATION CAN LEAD TO DENIAL OF CONSIDERATION. I HEREBY AUTHORIZE THE HOSPITAL TO MAKE ANY NECESSARY INQUIRIES TO VERIFY THE INFORMATION PROVIDED AND TO OBTAIN ANY ADDITIONAL INFORMATION REQUIRED BY FACILITY.

GUARANTOR SIGNATURE	DATE
SPOUSE SIGNATURE	DATE

- RELATIONSHIP OF HOUSEHOLD MEMBERS: Divorce Decree or Copy of Death Certificate
- PROOF OF RESIDENCY: Rent Receipt/Lease/Mortgage Statement or Room and Board/Support Letter; Utility Bills
- ASSETS: Bank and credit union statements for the last three (3) months
- INCOME FOR ALL HOUSEHOLD MEMBERS: Last (3) paycheck stubs/employer's statement listing gross wages, Social Security Award Letter for current year, or Unemployment Compensation Benefit Letter
- Most current W-2's and tax forms