Financial Assistance Application

Please complete the application to the best of your ability, and as fully as possible. This will help us answer your request as quickly as possible. If you would like to provide additional information of any kind that you feel will help us better understand your situation, please attach a letter to this application.

You must also provide proof of gross income. This may be in the form of your last three (3) pay stubs, last year's tax return, or other records documenting your year-to-date income.

PATIENT INFORMATION (PLEASE PRINT)

Account No. _____ Patient Name: _____

Birth Date: _____ Marital Status: _____ Sex: _____ SS#: _____

Address: _____ City: _____

State: ____ Zip: _____ Phone: _____ Email: _____

Employer: _____ Full Time ☐ Part Time ☐ Hours per week _____

Employer Address: _____ City: _____

State: ____ Zip: _____ Phone: _____

RESPONSIBLE PARTY'S INFORMATION

Name: _____

Birth Date: _____ Marital Status: _____ Sex: _____ SS#: _____

Address: _____ City: _____

State: ____ Zip: _____ Phone: _____ Email: _____

Employer: _____ Full Time ☐ Part Time ☐ Hours per week _____

Employer Address: _____ City: _____

State: ____ Zip: _____ Phone: _____

RESPONSIBLE PARTY SPOUSE INFORMATION

Spouse's Name: _____ SS#: _____ Birth Date: _____

Spouse's Employer: _____ Address: _____

City: _____ State: ____ Zip: _____ Phone: _____

DEPENDENTS

Name: _____ Age:_____ Relationship: _____

Name: _____ Age:_____ Relationship: _____

Name: _____ Age:_____ Relationship: _____

Name: _____ Age:_____ Relationship: _____

Name: _____ Age:_____ Relationship: _____

Premier Radiology

FINANCIAL ASSISTANCE APPLICATION

GROSS MONTHLY INCOME

Applicant Earned Income	
Applicant Spouse's Income	
Social Security Benefits	
Pension/Retirement Income	
Unemployment Compensation	
Worker's Compensation	
Interest/Dividend Income	
Child Support	
Alimony	
Rental Property Income	
Food Stamps	
Other	
Other	
TOTAL GROSS INCOME	$

ASSETS

Cash on Hand	
Savings Account	
Checking Account	
C.D.'s	
Securities	
Life Insurance	
Other Real Estate	
Other	

Vehicle / Make & Model	**Year**	**Value**

Financial Settlements:

Life Insurance	
Inheritance	
Other	
TOTAL VALUE OF ASSETS	$

MONTHLY LIVING EXPENSES

	Payment	Balance
Mortgage/Rent		
Electricity		
Gas		
Telephone		
Water		
Groceries		
Cable TV		
Car Payment		
Cell Phone		
Day Care		
Child Support/Alimony		
Prescription Drugs		
Credit Cards:		
1.		
2.		
3.		
Other Doctor/Hospital Bills:		
1.		
2.		
3.		
4.		
Insurance Expense:		
1. Automobile		
2. Property		
3. Medical/Life		
Other Loan Payments:		
1.		
2.		
Other Monthly Payments:		
1.		
2.		
3.		
TOTAL MONTHLY EXPENSES	$	$

COMMENTS: _____

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Date

Signature of Patient, Spouse, Guarantor or Legal Representative

Financial Application Checklist

Definition of Household to count for income and household size calculations:

1. All persons within the single family unit should be counted. This is defined as husband, wife and children.
2. All children 21 and older will not be included in the household size unless the child is in school full-time up to the age of 25.
3. Parents living in the home with their adult child will not count toward the household size or income of that child.
4. Common Law marriages will count toward income and household size.
5. Spouses who are separated will not count toward income and household size.
6. Significant Others will not count toward income and household size unless they have been living together for 6 months or longer.
7. Any persons that the patient is legally responsible for will count toward household size.
8. Grandparents taking care of grandchildren in the home where the parent is not in the home will count toward income and household size.
9. International Visitors - Applications will include the household income of the sponsor.

In order to process your application in a timely manner, please ensure all information is included and returned within 15 days.

☐ Previous year's tax return (20_____) showing gross amount of income and all dependents included on that tax return.

- **Copies of last 3 check stubs, including spouse's, if applicable. If social security, disability, retirement or unemployment benefits are included in monthly income, please enclose proof as well. APPLICATIONS WILL BE DENIED IF THIS IS NOT PROVIDED.**

☐ Copies of all current bills. (Utilities, rent/mortgage, medical/hospital bills, etc.)

☐ If you are not working and you rely on someone else for food and housing, a letter from that provider (enclosed Letter of Support) must be completed and notarized.

☐ If you receive food stamps you will need to provide proof documenting the amount you receive.

Should you have any questions in regards to completing this application please contact: 615-747-2984.

Please understand that incomplete applications, lack of returned information, or if the application is not returned within 15 days, this will cause the application to be denied.

PLEASE SUBMIT APPLICATION AND ALL REQUESTED DOCUMENTS BY EMAIL OR FAX TO:

Email: financialassistance@radpartners.com

Fax: 888-622-1655

If unable to email or fax application, please take to the closest Premier Radiology location.

Premier Radiology