

Tanner Medical Center Application for Financial Assistance

Tanner Health recognizes how unexpected medical situations can affect your finances. We offer a variety of options to assist with your medical bills including assistance for those who are uninsured or have an outstanding balance after insurance has been processed. The financial assistance application and supporting documents can be completed and uploaded within MyChart or mailed to our business office.

Applications must include the following documentation:

- **Federal tax return (Form 1040)**
- **Income verification (include all that apply)**
 - 3 current paycheck stubs
 - Proof of unemployment
 - Worker's compensation
 - Child support
 - Food stamps
 - Rental income
 - Social security
 - Disability
 - VA benefits
 - Pension
 - Annuities
 - Any other source of income
- **3 recent bank statements (include checking and savings)**
- **Other assets, properties, IRAs, CDs, stocks, and bonds**

NOTICE – Applications are based on household income.

Please include any of the above that applies to all members of the household.

Tanner Health is required to provide specific documentation to validate your participation in any assistance program. Your immediate attention and timely response are crucial.

*You may be contacted by a Tanner representative to discuss your application
or to obtain additional financial information.*

After the initial review of your financial information, your case may be referred to Firstsource, who will assist you in the application process for benefits under one of several government programs. Firstsource is a FREE referral service provided by Tanner Health. **It is vital to the application process that you cooperate with Firstsource in providing all requested documentation as quickly as possible.**

**Please submit your application and documentation through MyChart
or mail the attached application and supporting documents to:**

Tanner Medical Center
Business Office
ATTN: Patient Financial Counselors
705 Dixie Street
Carrollton, GA 30117

Incomplete applications will result in denials, and the account balance will be the patient's responsibility.

If you need assistance, call the Patient Financial Counselors office at 770-812-5795.

**Tanner Medical Center Application for Financial Assistance**

Date: _____

Patient: _____ MRN: _____

Guarantor Information

Name: _____ DOB: _____ SSN: _____

Address: _____ Rent or Own _____

City: _____ State: _____ Zip: _____ Phone #: _____

Claimable Dependents in Household (Names & DOBs): _____

Total # of Dependents in Household: _____

Employer: _____ Position: _____

Length of employment: _____ Employer Phone #: _____

Spouse, Parent, or Other Relative

Name: _____ DOB: _____ SSN: _____

Address: _____ Relationship to Patient: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Employer: _____ Position: _____

Length of employment: _____ Employer Phone #: _____

Financial Information

Bank Name: _____ Account Type: _____ Balance: _____

Bank Name: _____ Account Type: _____ Balance: _____

Other Accounts (IRAs, CDs, etc.) and Balances: _____

Assets

House/Property: _____ Balance: _____

Auto: _____ Balance: _____

Stocks/Bonds: _____ Balance: _____

Insurance Information

Primary Insurance: _____ Policy #: _____ Policyholder: _____

Secondary Insurance: _____ Policy #: _____ Policyholder: _____

Other Coverage: _____ Policy #: _____ Policyholder: _____

Income & Expenses

Income Source	Monthly Income
Gross Salary (Patient)	_____
Gross Salary (Spouse/Other)	_____
Pension	_____
Self-Employment	_____
Social Security	_____
VA Benefits	_____
SSI Benefits	_____
Child Support/Alimony	_____
Food Stamps	_____
All Other Income	_____
Total Monthly Income:	_____

Expense Description	Monthly Expense
Rent/Mortgage	_____
Food	_____
Car Payment/Insurance	_____
Fuel	_____
Total Utilities	_____
Phone/Internet	_____
Medical (Including Pharmacy)	_____
Monthly Loans	_____
Monthly Credit Cards	_____
All Other Expenses	_____
Total Monthly Expenses:	_____

I, _____ attest that the information provided on the Financial Analysis form completed by me, or someone on my behalf, is accurate to the best of my knowledge. I authorize Tanner Health to obtain any financial or other information necessary to make an accurate determination of my ability to pay. Further, I authorize Tanner Health to access my credit bureau file if deemed necessary.

Applicant Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Office Use Only	
Annual Income	\$ _____
Annual Expenses	\$ _____
Total Hospital Balances	\$ _____
Notes: _____	
Medicaid # (if applicable): _____ ☐ Check if Medicare	
I, _____, certify that the above is true and accurate.	
Date: _____	

Financial Assistance Policy Terms and Conditions

By signing below, I confirm that I understand and agree to the following:

- I agree to give complete income information for all household members and to send all required documents on time. If TMC discovers any information I have provided to be false or I fail to provide information, I understand that my application and/or approval status will be denied.
- **FirstSource (Medicaid Help):** If FirstSource contacts me, I must complete their screening or application. If I don't, Tanner Medical Center (TMC) will not approve or continue my financial assistance.
- **Liens or Legal Claims:** Financial assistance does not apply to accounts with court-filed liens. These must be settled in court or paid in full.
- **Changes in Income or Assets:** I must tell the Business Office if my income or assets change during the one-year assistance period. If my income increases and no longer qualifies, my financial assistance may be canceled early.
- **Hospital vs. Independent Providers:** Some doctors at TMC may not work for the hospital and may bill separately. TMC financial help only covers hospital bills. I can share my approval letter with other providers, but they do not have to accept it.
- **Elective or Non-Medically Necessary Procedures:** Financial assistance does not cover elective procedures (like cosmetic surgery) or care without a medical need. These are also not covered by insurance, and I will need to pay the full cost.

Patient/Responsible Party

Date

Responsible Party (if different from patient)

Date

Witness

Date

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