TANNER MEDICAL CENTER
705 DIXIE STREET
CARROLLTON, GA 30117
Phone # (770) 812-5795

Tanner Health System 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 a balance after insurance. To be considered for one of Tanner's assistance programs,

PLEASE COMPLETE THE ENCLOSED APPLICATION & MAIL WITH COPIES OF THE FOLLOWING:

- **Federal Tax Return (Form 1040)**

- **Income Verification: (include all that apply)**
  3 Current Pay Check Stubs, Proof of Unemployment, Worker's Compensation,
  Child Support, Food Stamps, Rental Income,
  Social Security, Disability, VA Benefits, Pension, Annuities, etc.
  Or 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 Medical is required to provide specific documentation to validate your participation in any assistance program. Your immediate attention and timely response is crucial.
Incomplete applications will result in denials and that account balance will be the patient's responsibility.

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 System. **It is vital to the application process that you cooperate with Firstsource in providing all requested documentation as quickly as possible. **

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

Please mail the application and supporting documents to:

Tanner Medical Center
Business Office
Attn: Patient Financial Counselor
705 Dixie Street
Carrollton, GA 30117

Tanner Health System

Financial Analysis for Credit ☐ *(eligible for Medicaid)*

Date: _____ Children/Dependants in Household

Patient: _____ _____

_____

Guarantor Information

Name: _____ # In Household: _____

Address: _____

City: _____ State: _____ Zip: _____ S. S. #: _____

Phone Number: _____ Rent/Own: _____ How long at this address: _____

Employed By: _____ How Long _____ Position: _____

Employer Phone: _____ Contact Person: _____

Spouse, Parent or Other Relative

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ S. S. #: _____

Employed By: _____ How Long _____ Position: _____

Employer Phone: _____ Contact Person: _____

Financial Information

Checking Account With: _____ Acct #: _____ Balance: _____

Savings Account With: _____ Acct #: _____ Balance: _____

IRA/CD's: _____

Assets

House/Property: _____ Balance: _____

Land/Property: _____ Balance: _____

Auto: _____ Balance: _____

Stocks/Bonds: _____ Balance: _____

Insurance Information

Primary Ins: _____ Policy # _____ Phone _____

Secondary Ins: _____ Policy # _____ Phone _____

Other Private Policies (AARP,Cancer, etc) _____

Policy #: _____ Phone #: _____

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 System to obtain any financial or other information necessary to make an accurate determination of my ability to pay. Further, I authorize Tanner Health System to access my credit bureau file if deemed necessary.

Applicant Signature _____ **Date:** _____

Witness Signature _____ **Date:** _____

Tanner Health System - Financial Analysis Worksheet

Income Description	**Monthly Income**
A. Gross Salary Patient	
B. Gross Salary	
Spouse/Other	
C. Pension Income	
D. Self Employment	
E. Social Security	
F. VA Benefits	
G. SSI Benefits	
H. Child Support/Alimony	
I. Food Stamps	
K. Other:	
Total Monthly Income:	
Copied Tax Return	☑

FOR OFFICE USE ONLY

Annual Income $ _____
(K times 12)
Annual Tax Refund $ - _____
Misc. Expenses $ - _____ (# in HH)

Annual Expenses $ _____ (R times 12)
Remaining Income _____
(Income less Expenses)

I _____ certify that the above information is true and accurate.
Date:

Monthly Expense Description	
A. Rent or House Expense	
B. Food	
C. Electric/Power	
D. Water	
E. Phone	
F. Gas	
G. Installment Loan	
H. Car Payment	
I. Car Insurance	
J. Visa	
K. Capitol One	
L. Sears	
M. Cable/Dish	
N. Other Ins. Life/Cancer	
O. Medical	
Insurance (house, etc.)	
Taxes (property, etc.)	
P. Pharmacy	
Q. Auto Gasoline	
Total Monthly Expenses	

Medicaid # if applicable: _____

3. Summary & Analysis Description

FOR OFFICE USE ONLY

1. Annual Family Income _____
2. Number In Household _____

3. Applicable Guideline Used _____
(Charity or Indigent) _____

4. Percentage of Charity Allowed % _____
5. Total Charges Considered for PFAP $ _____
6. Patient's Liability for Bill $ _____
(# 5 less discount %)

Patient's Acct. Adjustment $ _____
(#5 Charges x #4 % Charity = Adjustment)

Approved (Check) _____
Disapproved (Check) _____
(Does not meet financial guidelines)

Adjustment Code: _____

_____ ***Check if Medicare***

Account	*>12 mo*	*Adj.*	*>12 mo*	*Account*	*Adj.*

Interviewed By: _____ *Date* _____

Reviewed By _____ *Date* _____

Approved By: _____ *Date* _____

Posted Date: _____ *Batch #:* _____

CONDITIONS FOR FINANCIAL ASSISTANCE

A. **Firstsource (Medicaid Eligibility Services)**

If you are notified by Firstsource, you must complete their screening/ application process. Otherwise, Tanner will be unable to administer this discount.

B. **Liens/Third Party Liabilities**

Financial assistance does not release nor pardon any amount due or lien filed through the court system in relation to third party liabilities.

C. **Change in Income/Assets**

Patients are required to notify the Business Office of any change in income/assets.

D. **Physician/Hospital Relationship**

Healthcare professionals performing services in this hospital may be independent contractors & are responsible for their own actions & billing. TMC shall not be liable for their services.

E. **New Hospital Accounts**

It is the patient's responsibility to contact our office when new billing statements are received.

F. **Elective Procedures/Medical Necessity**

Financial assistance may not cover elective procedures.

I understand & agree to the terms listed above.

Patient/Responsible Party	***Date***
Responsible Party (if different from the patient)	***Date***
Witness	***Date***