Good Samaritan Hospital
P.O. Box 290969
NASHVILLE, TN 37229

Dear Patient/Responsible Party:

Thank you for choosing Good Samaritan Hospital for your recent health care needs. Upon review of your account we recognized that you may qualify for our Financial Assistance Program. In order to be considered for the program, you must complete, sign, and return the enclosed Financial Assistance Application within fourteen (14) days of receipt.

The attached form applies to hospital bills you received at this facility, and other medical bills you or your family may have incurred throughout the year.

Inpatient Visits, Including Medicare Patients: If you were admitted into the hospital as an inpatient, it is necessary for you to provide us with one of the following for supporting documentation. If you did not file a tax return, please indicate and attach any two of the documents listed below:

* Federal Income Tax Return
* State Income Tax Return
* Last 3 Employer Pay Stubs

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.

Please allow twenty-one (21) business days for our review process. We will notify you of our financial assistance determination in writing. If you have any questions or concerns, please feel free to contact Customer Service at any time.

Sincerely,
Customer Service
Phone: 800-307-7631
Fax: 833-336-8190
Hours: 8:30AM-5:00PM

PO Box 290969
NASHVILLE, TN 37229

Financial Assistance Application

☐ Application for Charity Assistance – Complete Sections 1 & 3
☐ Application for Discount Payment Plan – Complete Sections 1, 2 & 3

Section 1

To be completed for applying for Financial Assistance or Discount Payment Plan

Hospital Name: _____
Account Number: _____
Patient Name: _____
Patient Social Security Number: _____
Responsible Party Name: _____
Responsible Party Social Security Number: _____

Dependents in Household

This includes spouse, children under 18 and all others claimed on your tax return)

Name: (First, Middle and Last Name if different than Patient) **Age:**

_____ _____
_____ _____
_____ _____
_____ _____

Employment (Patient/Responsible Party)

Employer Name:			
Hourly Rate:		Hours Worked Per Week:	
Current Gross Weekly, Monthly or Yearly Income (before taxes):			
If unemployed, date last worked:			

Spouse Employment

Employer Name:			
Hourly Rate:		Hours Worked Per Week:	
Current Gross Weekly, Monthly or Yearly Income (before taxes):			
If unemployed, date last worked:			

Other Income

		Patient		Spouse
Social Security				
Pension				
Unemployment				
Worker's Compensation				
VA Benefits				
Rental Income				
Stocks, Bonds, 401k				
Dividend/Interest				
Child Support				
Alimony				
Other				

Section 2

To be completed for Discount Payment Plan

Monthly Family Household Expenses

Housing	Essential Expense Amount
Mortgage or Rent	
Second Mortgage or Rent	
Condo or Association Fees	
Insurance	
Electricity / Gas	
Water / Sewer	
Waste Removal	
Maintenance / Repairs	
Lawn Care	
Phone /Cell Phone	
Internet	
Cable / Satellite	
Other	

Food and Laundry	Essential Expense Amount
Groceries	
Laundry and Cleaning	

Transportation	Essential Expense Amount
Car Payment 1	
Car Payment 2	
Auto Insurance	
Gas	
Parking	
Bus / Taxi Fare	
Maintenance / Repairs	
Licensing / Tags	
Other	

Taxes	Essential Expense Amount
Federal	
State	
Local	
Other	

Personal	Essential Expense Amount
Clothing	
Personal Care	
Child Care	
Elder Care	
Professional Fees (Legal, Tax)	
Alimony	
Child Support	
Other	

Health Care and Insurance	Essential Expense Amount
Medical Services	
Dental Services	
Prescriptions and Medications	
Health Insurance	
Long Term Care Insurance	
Life Insurance	
Other	

Total Income: _____
Total Essential Expenses: _____

Section 3

To be completed for Financial Assistance or Discount Payment Plan

Have you applied for Medicaid or any other State/County Assistance? ☐Yes ☐No
If yes and known, Case Number: _____ Date Applied: _____

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to help pay this hospital bill prior to completing this application.

Signature: _____ Date: _____
(Patient, Responsible Party, etc.)