

CONFIDENTIAL
Morristown-Hamblen Healthcare System
Financial Assistance Application

Patient Name _____ Account # _____

Dependents living with you. Only include individuals that you can claim on your tax return.

Name	Birth Date	Social Security #	Relationship

Annual Family Income (Gross Amount before deductions)

Guarantor's Employment \$	Social Security \$
Spouse's Employment \$	Unemployment \$
Retirement Income \$	Child Support \$
Alimony \$	10% of Assets \$
Public Assistance \$	Grand Total \$
Other (specify) \$	
Worker's Comp \$	Future Income (Pension, Social Security) \$

Assets – DO NOT LEAVE ANY BLANKS

Cash on hand/money in the bank, savings, etc. \$	
Stocks/bonds/securities (cash value) \$	
Cash value of real estate where you live \$	Balance owing \$
Cash value of rental/ other property \$	Balance owing \$
Cash value of business property \$	Balance owing \$
Cash value of farm land \$	Balance owing \$
Cash value of farm equipment (include crops and livestock) \$	Balance owing \$

Monthly Expenses

Automobiles	Car "A"	Car "B"	Car "C"
Year/Make/Model			
Balance owing			
Monthly Payments			

Description	Monthly Amount	Balance Owing	Comments
Rent/mortgage \$			
Installment Loans \$			
Credit Cards \$			
Medical Bills \$			
Medical Insurance\$			
TOTAL			

Internal Use Only

Food Allowance

Utility Allowance

I affirm that the above information is true and correct to the best of my knowledge. I understand that the above information may be verified and/or my credit report may be obtained for the sole purpose of qualifying me or my dependent for financial assistance.

Applicant's signature _____

Date _____