HC HENRY COUNTY
MC MEDICAL CENTER

PATIENT FINANCIAL ASSISTANCE APPLICATION

Henry County Medical Center Financial Assistance Policy Requirements

ALL steps must be completed before applying for the program. Once completed, contact a financial counselor to schedule an appointment to complete the Medically Indigent Application.

1. Apply for Tenncare through the Health Insurance Marketplace via www.healthcare.gov or by calling 1-800-318-2596. Present the confirmation number or letter.

2. Apply for Food Stamps at your local Department of Human Services Center. If you already receive them, provide proof of the amount. (You may want to speak with a counselor about income requirements; you may not have to apply).

3. Provide a copy of your **LAST Income Tax Return**, if it's **NO MORE THAN TWO YEARS OLD**.

4. Provide **Bank Statement(s)** of ALL Bank accounts for ALL applicants. (Checking, Savings, etc.)

5. Provide **Proof of Income** (last 4 check stubs from **ALL** employment(s). This is **REQUIRED** for **ALL** individuals on the application. *Applicants receiving **SSI/SSA** income can use their bank statement showing Direct Deposit for this step*.

- The requested information is needed to help determine eligibility to receive financial assistance for hospital charges. (This program may not include professional charges received from Physicians, Radiologists, Anesthesiologists, etc).

- In addition to your income, the discount will also take into account the size of your household, in accordance with the Federal Poverty Guidelines. HCMC provides financial assistance up to 250% of the federal poverty level.

Please submit your completed application to our Financial Counselor:
Lynn Frantom, 731-644-8595 or llfrantom@hcmc-tn.org
Send apps to:
HCMC, PO Box 1030, Paris, TN 38242
Fax 731-644-8587

HENRY COUNTY MEDICAL CENTER

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PATIENT'S NAME: _____

ADDRESS: _____

_____

PHONE: _____

ACCOUNT# (list all related to this app) _____

DATES OF SERVICE: _____

GUARANTOR'S NAME: _____

Number of related persons in household: ____ **Marital Status (Circle One): SINGLE MARRIED DIVORCED SEPARATED WIDOWED**

(Household INCLUDES: Guarantor (Applicant), Guarantor's Spouse, Guarantor's unmarried partner if they have a child together, and minor children/ dependents residing in the home. (Will use Income Tax Return and/or Food Stamp Letter to verify)

Please list Names and Dates of Births for EACH HOUSEHOLD MEMBER Below:

Name: _____ **DOB:** __/__/__ **Name:** _____ **DOB:** __/__/__

Name: _____ **DOB:** __/__/__ **Name:** _____ **DOB:** __/__/__

Name: _____ **DOB:** __/__/__ **Name:** _____ **DOB:** __/__/__

Patient and/or responsible party employed? Yes or No Employment Info: _____

If not currently employed, provide employment history and plans for future employment: _____

HOUSEHOLD MONTHLY INCOME- (Please Specify)

Gross Monthly Salary (Applicant) - $ _____

Gross Monthly Salary (Spouse) - $ _____

Social Security or SSI - $ _____

VA Benefits - $ _____

Alimony and/or Child Support - $ _____

Food Stamps, AFDC, Public Housing, etc. - $ _____

Savings/Checking Account Balance - $ _____

CD or IRA Balance - $ _____

Other Income (Specify Source and Amount) – $ _____

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I certify that the information given in the application for financial assistance is true and accurate to the best of my knowledge and that the facility may take any reasonable action to verify it. If any information I have given to the hospital proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate. Further, I will make an application for any assistance (Medicaid, TennCare, Medicare, insurance, Liability coverage, Motor Vehicle Insurance, etc) which may be available for payment of my hospital charges. I will take any action reasonable necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for the hospital charge. If I am approved for less than a 100% discount, I agree to make payment arrangements for the balance.

DATE:_____ SIGNATURE OF APPLICANT:_____

HOSPITAL USE ONLY

TOTAL MONTHLY INCOME: _____ TOTAL ANNUAL INCOME: _____

APPROVED: _____ DISCOUNT AMOUNT: _____%

DENIED: _____ REASON FOR DENIAL: _____

DATE AUTHORIZED: _____ AUTHORIZED BY: _____

Director of Patient Financial Services

Annual 2024 Poverty Guidelines for the 48 Continental United States					
Household / Family Size	100%	150%	200%	250%	300%
1	$15,060	$22,590	$30,120	$37,650	$45,180
2	$20,440	$30,660	$40,880	$51,100	$61,320
3	$25,820	$38,730	$51,640	$64,550	$77,460
4	$31,200	$46,800	$62,400	$78,000	$93,600
5	$36,580	$54,870	$73,160	$91,450	$109,740
6	$41,960	$62,940	$83,920	$104,900	$125,880
7	$47,340	$71,010	$94,680	$118,350	$142,020
8	$52,720	$79,080	$105,440	$131,800	$158,160
9	$58,100	$87,150	$116,200	$145,250	$174,300
10	$63,480	$95,220	$126,960	$158,700	$190,440
Discount %	100%	100%	100%	80%	70%