

Vanderbilt University Medical Center Financial Assistance Application

VUMC is committed to care for all patients regardless of their ability to pay. Patients who are unable to pay for services may be eligible for financial assistance. Please complete and return the following form to be evaluated for financial assistance.

Applicant Name <i>(First, Middle, Last)</i>	Services Locations and Dates	Account Number(s)
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Instructions: Complete application and attach copies (no originals) of:

- Tax returns and supporting schedules (previous 2 years)
- Social Security/Disability* (if applicable)
- W-2 or Unemployment Statements*
- Pay stubs* (most recent 3 months)
- Food Stamp Letters* (if applicable)

*NOTARIZED LETTERS ARE NOT ACCEPTED

Patient/Responsible Party

Name <i>(First, Middle, Last)</i>		Social Security Number	Birth Date <i>(Month DD, YYYY)</i>
Address		City	State
ZIP Code		Phone	
Household Size <i>(Patient, Spouse and Dependents)</i>		Marital Status	
Employment Status		Employer Name	
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student			
Employment Length	Unemployed Date/Length <i>(Month DD, YYYY)</i>	Are you claimed on another tax return?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes provide tax returns of those being claimed)	

Spouse/Partner

Name <i>(First, Middle, Last)</i>		Social Security Number	Birth Date <i>(Month DD, YYYY)</i>
Employment Status		Employer Name	
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student			
Employment Length	Unemployed Date/Length <i>(Month DD, YYYY)</i>		

Dependents (If more than 3 dependents use separate page)

Full Name	Relationship	Birth Date
1.		
2.		
3.		

Certification

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by VUMC or an affiliated entity and I give permission to VUMC and all affiliated clinics, hospitals and entities to share the information as necessary to consider my financial assistance request. I hereby grant permission to VUMC, all VUMC affiliates and representatives or agents to investigate the information contained herein, and to obtain credit reports.

Patient/Responsible Party Signature	Date <i>(Month DD, YYYY)</i>
Spouse/Partner Signature	Date <i>(Month DD, YYYY)</i>

In 4 to 6 weeks, you will receive a letter to inform you if you are eligible for financial assistance for an approved service. If you receive an approval letter, it does not mean that all services at VUMC are approved or that future services will be approved for financial assistance. Please call VUMC Patient Billing Customer Service Team at 888-274-7849 to reapply. You can also email or mail in a new application. If you receive a letter informing you are not eligible for financial assistance and wish to appeal the decision, you can appeal the decision by emailing, mailing or faxing a completed VUMC Financial Assistance Appeal Application.