VANDERBILT UNIVERSITY MEDICAL CENTER

# 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 *(First, Middle, Last)* | Services Dates | Account Number(s) |
|---|---|---|
| | | |

**Instructions: Complete application and attach copies (no originals) of:**

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

**Service Location(s)**

- ☐ **Vanderbilt Medical Center (VUMC)**
- ☐ **Vanderbilt Wilson County Hospital (VWCH)**
- ☐ **Vanderbilt Tullahoma-Hardin (VTHH)**
- ☐ **Vanderbilt Bedford Hospital (VBCH)**

## Patient/Responsible Party

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

## Spouse/Partner

| Name *(First, Middle, Last)* | | Social Security Number | Birth Date *(Month DD, YYYY)* |
|---|---|---|---|
| Employment Status ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student | | | Employer Name |
| Employment Length | Unemployed Date/Length *(Month DD, YYYY)* | | |

## Dependents (If more than 3 dependents use separate page)

| Full Name | Relationship | Birth Date *(Month DD, YYYY)* |
|---|---|---|
| 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 *(Month DD, YYYY)* |
|---|---|
| Spouse/Partner Signature | Date *(Month DD, YYYY)* |

In 4 to 6 weeks, you will receive a letter to inform you if you are eligible for financial assistance. 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.

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