



Financial Assistance Application

Date: _____

Patient Name _____ SS # _____

Facility: _____ Account # _____

Guarantor Name _____ SS # _____

Date of Birth _____ Telephone # _____

Number in household: _____

Street Address: _____

City _____ State _____ Zip _____

Signature _____

By signing this application, you are giving Wellmont Health System permission to run a charity application. Additional information may be required to make a determination.

**Please mail completed work sheet to: Wellmont Health System
Patient Financial Services
P. O. Box 1089
Bristol, TN 37621-9916**

Approved: _____ Date: _____ Denied: _____ Date: _____

Processed by: _____

Managers Approval: _____

Approvals are for 90 days only. A new application must be completed if future assistance is needed.