Regional One Health

Patient Assistance Program Application

Personal Information:

Last Name _____ First Name _____ Middle Initial _____
SSN _____ Date of Birth _____
Drug/Food Allergies _____
Address _____ City _____ State ____ Zip _____
Home Phone _____ Employer Name _____ Work Phone _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Spouse/Other Information:

Last Name _____ First Name _____ Phone _____
Spouse SSN _____ Spouse Date of Birth _____
Spouse/Other Employer _____

Monthly Gross Household Income Information:

For You _____ For Spouse _____ For Other _____
Number of Dependents _____ Age(s) of Dependents _____
Are you employed? ☐ Yes ☐ No ☐ Full time ☐ Part time ☐ Retired ☐ Other
Did you file income tax in 20__? ☐ Yes ☐ No Are you a veteran? ☐ Yes ☐ No
Do you receive Food Stamps? ☐ Yes ☐ No If so, how much _____

Insurance Information:

Will any of these charges be handled by an attorney? ☐ Yes ☐ No
Do you have Medical Insurance? ☐ Yes ☐ No
Do you have Medical Insurance/Medicare/Medicaid that pays for your medications?
☐ Yes ☐ No

Name of Insurance _____ Insurance/Medicare ID Number _____

Have you applied for?					What were the results?				
Tenncare	☐	Yes	☐	No	☐	Yes	☐	No	☐ Pending
Medicaid	☐	Yes	☐	No	☐	Yes	☐	No	☐ Pending
Social Security	☐	Yes	☐	No	☐	Yes	☐	No	☐ Pending
Disability	☐	Yes	☐	No	☐	Yes	☐	No	☐ Pending
Crime Victim's Comp.	☐	Yes	☐	No	☐	Yes	☐	No	☐ Pending
Workman's Comp.	☐	Yes	☐	No	☐	Yes	☐	No	☐ Pending

I am requesting that consideration be given to me by Regional One Health for Uncompensated Care and/or reduced cost medications. I understand that the information which I submit concerning my annual income and family size is subject to verification by Regional One Health. I also understand that if the information which I submit is determined to be false, such a determination will result in denial of services provided as uncompensated and /or reduced cost medications, and I will be liable for charges incurred. Furthermore, I am aware that this is a voluntary service by Regional One Health, and they maintain exclusive rights ro approval or denial.
I affirm that the information provided is true and correct to the best of my knowledge.

Signature _____ *Date* _____

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