Patient Financial Services Department
257 Bancorp South Pkwy
Jackson, TN 38305
Phone: 800-233-2108
Fax: 731-541-1421

PAY PLAN ASSESSMENT (PPA) FORM

Patient account balances are the responsibility of the account guarantor and either payment in full or other approved payment arrangements are required within thirty (30) days of initial billing to keep the accounts in good standing. If patient account balances cannot be paid in full within 120 days of initial billing, then the completion of this form is necessary for the establishment of acceptable payment amounts and frequency to satisfy your patient account balance. The information on this form is used only for the purpose of determining an acceptable payment arrangement. If a satisfactory payment arrangement or payment plan is not established or if promised payment arrangements or payment plans are not fulfilled, the patient account will be subject to continued collection efforts that may include referral to an outside collection agency, credit reporting, and/or litigation. This form should be completed fully and accurately and misleading or incomplete information may result in denial of any payment arrangement other than payment in full.

SECTION 1: PATIENT INFORMATION AND PAY PLAN REQUEST					
PATIENT NAME:					
ENCOUNTER NUMBER(S):					
DOB:		SSN:		TELEPHONE #	
I am requesting a per month payment amount of:		**$**			

SECTION 2: GUARANTOR INFORMATION (If same as the patient, skip to section 3)					
GUARANTOR NAME:					
GUARANTOR ADDRESS	STREET:				
	CITY, STATE, & ZIP:				
DOB:		SSN:		TELEPHONE #	

SECTION 3: HOUSEHOLD INFORMATION

Please complete the following information for yourself as well as each other person who currently lives at your place of residence or has lived at your place of residence for six out of the past twelve months. Members of the household consist of all persons, both related or unrelated, who occupy the same place of residence.

NAME	AGE	CURRENTLY EMPLOYED? (Y OR N)	EMPLOYER	**NET** MONTHLY INCOME

SECTION 4: OTHER INCOME AND ASSETS		
OTHER INCOME	Other monthly household income amount (include child support received, alimony, food stamps, etc):	
	Other monthly household income source:	
OTHER ASSETS*:		*Cumulative Balance of all other **LIQUID** assets to include checking and savings account balances, stocks, bonds, investments, etc. that may be immediately available for use. Do not include personal or business property.

WEST TENNESSEE HEALTHCARE PAY PLAN ASSESSMENT (CONTINUED)

SECTION 5: MONTHLY HOUSEHOLD EXPENSES

MONTHLY LIVING PAYMENTS:

ITEM	MONTHLY AMOUNT		ITEM	MONTHLY AMOUNT
Housing (including property taxes, insurance, etc.):			Other Monthly Living Payment 1: (Specify below)	
Utilities (Electricity, Water, Gas, Sewer):				
Food/Groceries:			Other Monthly Living Payment 2: (Specify below)	
Auto Loan/Lease/Insurance Payments:				
Phones (Cell and Land):			Other Monthly Living Payment 3: (Specify below)	
Cable/Satellite/Internet:				
Child care/School/Support Paid (not received):			Other Monthly Living Payment 4: (Specify below)	
Transportation (including gas):				

MONTHLY CREDIT AND OTHER MEDICAL PAYMENTS

CREDIT CARDS	BALANCE:		**OTHER HOSPITAL BILLS:**	BALANCE:	
	MONTHLY PAYMENT:			MONTHLY PAYMENT:	
OTHER PERSONAL LOAN 1 (Specify below)	BALANCE:		**OTHER DOCTOR BILLS:**	BALANCE:	
	MONTHLY PAYMENT:			MONTHLY PAYMENT:	
OTHER PERSONAL LOAN 2 (Specify below)	BALANCE:		**OTHER MEDICAL BILLS:** (Medicine, Dental, Product, etc.)	BALANCE:	
	MONTHLY PAYMENT:			MONTHLY PAYMENT:	

SECTION 5: ADDITIONAL INFORMATION

Additional information that may explain why the information does not portray a complete picture of financial status to be considered when establishing a payment plan can be submitted for consideration. If additional information is being submitted, please indicate this information in this section.

FORM OF ATTACHMENT (Letter, proof of other expenses, etc.)

SECTION 6: CERTIFICATION

I certify that all the information provided on this form is true and accurate to the best of my knowledge. I understand that providing false, misleading, or incomplete information may result in the denial of any payment arrangement other than payment in full. Furthermore, I understand that providing false representations of the information contained on this application constitutes an act of fraud. I hereby authorize WTH to make inquires necessary to verify the information contained in this application and will supply supplemental information as necessary. **Failure to supply ALL income and monthly obligations can and will keep you from being approved for the payment plan that you are requesting. This form must be completed and returned to the Patient Financial Services Department within 30 days to be considered for an extended payment plan.**

Applicant's Signature	Date

SECTION 7: INTERNAL USE ONLY – COMPETED BY WTH HOSPITAL BILLING DEPARTMENT STAFF

Date of Receipt:		Monthly Payment Plan Amount:	
Cumulative Account Balances:		Payment Plan Period:	
Initials of Reviewing Staff:		Initials of Approving Staff:	