THE UNIVERSITY OF TENNESSEE
HEALTH SCIENCE CENTER

AUDIOLOGY AND
SPEECH PATHOLOGY

UTHSC Audiology and Speech Pathology Clinics
Financial Assistance Application

The University of Tennessee Health Science Center Audiology and Speech Pathology clinics require patients to show proof of income to qualify for our sliding fee scale discounted fees and/or patient scholarship support. Please complete the following form and bring it, along with documentation indicated below, to your appointment. You may also mail the *form and documentation* to our business manager at UT Conference Center, Department of Audiology and Speech Pathology, 600 Henley Street, Suite 110B, Attn: Ms. Colleen Oakley.

Patient First and Last Name

_____

Patient Date of Birth _____ **Age** _____

Does the patient have health insurance? [ ] Yes [ ] No

Insurance Provider _____ **Policy Number** _____

Address _____

Phone Number _____

HOUSEHOLD INFORMATION

Household Size _____ **# of Adults** _____ **# of Minors** _____

Name of HOH/Parent/Guardian	Date of Birth	Employed	Gross Annual Pay	Number of Dependents*
		YES / NO	$	
		YES / NO	$	

*Number of dependent children you will claim in the current year as Federal Tax Exemptions.

Name of Dependent	Date of Birth

ANNUAL GROSS HOUSEHOLD INCOME _____

*This number should be supported by documentation provided according to the following list.

Documentation to Include with this Form for <u>EACH</u> income earner in the household

- Most current benefits statement letter from the Social Security Administration and/or retirement plan
  -or-
- Most recent federal income tax return
  -or-
- Most recent three months of bank statements
  -or-
- Most recent pay stub(s) or income verification letter from employer
  -or-
- Letter that shows you receive other Public Assistance (food stamps, etc.)

Explanation of Extenuating Circumstances

Sometimes there is additional information about this patient and family that would be helpful to us in making the decision about qualification for assistance. Please provide that information here.

_____

_____

_____

_____

_____

Signature of Patient or Guardian: _____

DISCLAIMER: I hereby certify that the above information is, to the best of my knowledge, true and correct. I further agree to notify the UT Hearing & Speech Center of any changes in this information within thirty (30) days of such change.
I understand that I must re-qualify annually to maintain my eligibility.
I am also aware that this information is reviewed and based upon Federal Poverty Guidelines, published annually by the Federal Government. Sliding Fee payment is due and payable at the time of service. To maintain discount, fees must be paid promptly.

Return completed Application and Proof of Income to:

600 Henley St. Suite 110B, Knoxville TN 37996

Attn: Director of Operations

If questions, please contact Ms. Colleen Oakley at (865) 974-1778

---------- For Office Use Only ----------

Date Received _____ Anticipated Cost _____

Does this patient attend their appointments/wear their current amplification consistently? Yes [ ] No [ ]

Applicable Fund(s) SR [ ] TC [ ] JC [ ] R [ ] SFS [ ] % _____

Committee Review Date _____ Application Approved Yes [ ] No [ ]

Awarded products/services or amount _____