Lift Wellness Center
101 Jackson Walk Plaza
Jackson, TN 38301
Phone: 731-427-7048
Fax: 731-425-6878

LIFT WELLNESS SCHOLARSHIP APPLICATION

The completion of this application is necessary for determination of eligibility for charity care or financial need discount programs with West Tennessee Healthcare (WTH). Supplemental information is required in addition to this application in order to make a full determination of eligibility. The application should be completed fully and accurately and misleading or incomplete information may result in denial of eligibility for any financial assistance programs with WTH.

SECTION 1: APPLICANT INFORMATION					
APPLICANT NAME:					
APPLICANT ADDRESS — STREET:					
APPLICANT ADDRESS — CITY, STATE, & ZIP:					
DOB:		SSN:		TELEPHONE #	

SECTION 2: MEMBERS OF HOUSEHOLD

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	DOB	RELATIONSHIP	CURRENTLY EMPLOYED? (Y OR N)	EMPLOYED IN THE LAST YEAR? (Y OR N)	EMPLOYER

SECTION 3: BANKING, INVESTMENTS, AND OTHER ASSETS				
CHECKING ACCOUNT	Do you have a personal checking account? YES ☐ NO ☐			
	Name of bank:		Current Balance:	
SAVINGS ACCOUNT(s)	Do you have savings account(s)? YES ☐ NO ☐			
	Name of bank(s):		Cumulative Balance:	
OTHER ASSETS (Stocks, Bonds, Investments, etc.)	Cumulative Balance of all other **LIQUID** assets (Not property, houses, etc.) that may be immediately available for use:			

PLEASE CONTINUE TO THE NEXT PAGE OF THE APPLICATION

SECTION 4: GROSS ANNUAL INCOME

Proof of gross annual income is required for all members of the household listed in Section 2 of this application. Gross annual income is the amount of income earned prior to any deductions for taxes, health care, or any other deductions from payments and/or benefits. Examples of accountable income include (but are not limited to) payroll or wages, tips earned, Social Security Income, disability income, alimony, child support, proceeds from benefit plans, cash gifts, grant income, and any other form of earned income**.** If the applicant or other members of the household claim no income, the Certification of Zero Income Form must be completed. **Acceptable proof of income is: payroll check stubs with year to date earnings listed, immediate previous year's Federal tax forms, copies of benefit letters stating the amount of paid benefits received, and/or acceptable attestations of payment amounts and frequency from employers or renderers of cash gifts.** In the case of self-employed applicants, documentation of income and expenses for any time period not covered by a provided tax form is required. Completion of IRS Form 4506-T may be required for the applicant or household members.

HOUSEHOLD MEMBER	SOURCE OF INCOME	AMOUNT RECEIVED	FREQUENCY OF PAYMENT	FORM OF PROOF ATTACHED

SECTION 5: ADDITIONAL INFORMATION

Additional information such as reason for requesting financial assistance, reasons for not being able to supply the requested information, and/or explanation of changes in financial situations may be attached to this application. If additional information is being submitted, please indicate this information in this section.

INFORMATION ATTACHED? (Y or N)	FORM OF ATTACHMENT (Letter, proof of other expenses, etc.)

SECTION 6: APPLICANT CERTIFICATION

I certify that all the information provided on this application 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 this application and denial of eligibility for any financial assistance programs with WTH. 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 I authorize WTH to release this information to any Business Associates or governmental agencies that may require it.

Applicant's Signature	Date

If someone assisted the patient in the completion of this application, please complete the following information.

Signature	Date	Telephone Number

Printed Name	Relationship to the Applicant:

(Internal Use Only) Date of receipt at Lift Wellness Center: _____