DCH HEALTH SYSTEM
Financial Assistance
809 University Blvd. East
Tuscaloosa, AL 35405
Phone: (205) 750-5004

As a community-owned, not-for-profit organization, DCH Health System is committed to providing quality health services to all residents of Tuscaloosa and West Alabama in a financially responsible manner. DCH does not refuse care for financial reasons to any patient requiring a medically necessary procedure.

We recognize that uninsured persons have special needs as they seek health-care services. In order to better meet the needs of the uninsured, we offer a wide range of services to help uninsured patients receive care. We also have processes in place to access the financial status of uninsured patients in order to help them possibly secure coverage or take advantage of special programs within the DCH Health System. We also want to ensure that our patients know what, if any, financial obligations they will have and those payment options available to them.

You may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients. If you would like to apply, you will need to complete the attached application, sign and date, returning it to the following address:

DCH HEALTH SYSTEM
FINANCIAL ASSISTANCE
809 UNIVERSITY BLVD. EAST
TUSCALOOSA, AL 35405

Feel free to call our Business Office at (205) 750-5004 or (205) 750-5790

*** Please note that the DCH Financial Assistance Program only applies to DCH hospital accounts, therefore, this application does not apply to any physician's professional fees.**

Financial Assistance Application

APPLICANT INFORMATION		
Account Number(s):		
Patient Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
☐ Own ☐ Rent ☐ Other _____	Monthly payment:	Years there:
Number of Children in family under 19:		

EMPLOYMENT INFORMATION		
Guarantor's Current employer:		
Employer address:		Hire Date:
Phone:	E-mail:	Fax:
City:	State:	ZIP Code:
Position:	☐ Hourly ☐ Salary	Annual income:

SPOUSE'S INFORMATION		
Spouse's Name:	DOB:	SSN:
Spouse's Current employer:		
Employer address:		Hire Date:
Phone:	Email:	Fax:
City:	State:	Zip Code:
Position:	☐ Hourly ☐ Salary	Annual income:

OTHER ASSETS OR SOURCES OF INCOME	
Description	Amount per month or value

I understand that the information that I submit is subject to verification and subject to review by the Federal and State enforcement agencies and others as required. I certify the above information is true and correct.

The following documents must be provided to verify income and family size:

- All sources of income including Paycheck Stubs, Food Stamps, Social Security, and SSI
- Income Tax Form(s)
- Bank Statement(s)

If there is no supporting documentation provided with this application, Financial Assistance would automatically be denied.

I understand that DCH's Financial Assistance Program, if approved, would apply to DCH hospital accounts only and would not apply to any physician's professional fees.

Signature of applicant:	Date: