

Thyme Care Medical
Patient Assistance Program
PO Box 282462 Nashville, TN 37228
Phone Number: (201) 526-8484
Email: thymecaremedical@thymecare.com



Application for Thyme Care's Patient Assistance Program

Applicant information:

Full Name:

Date of Birth:

Address:

City: State: Zip Code:

Phone Number:

Email Address:

Household Size:

Income information:

Please list the people who live in your home and how much money they make in a year.

Name	Relationship	Monthly Income
		\$
		\$
		\$
		\$
		\$
		\$
		\$

Total Monthly Household Income:

Documentation required:

Please include copies of at least 1 of these documents with your form:

- Recent pay stubs (from the last 2 months)
- Last year's tax form
- Proof of help from the government (like Medicaid, SNAP, SSI)
- Bank statements

Your promise:

I,, promise that everything in this form is true and correct as far as I know. I understand that if I give the wrong information, my application for help might be denied. I give Thyme Care Medical permission to check my information, including my income and family size.

Full Name: Date:
(Print)

Signature:
(Sign)