

Thyme Care Medical
Member Payment Support Program
PO Box 282462 Nashville, TN 37228
Phone Number: (201) 526-8484
Email: paymentsupport@thymecare.health



Application for Thyme Care’s Payment Support Program

Applicant Information:

Full Name:
Date of Birth:
Address:
City: State: Zip Code:
Phone Number:
Email Address:
Household Size:

Income Information:

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)