Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

DOB: _____ MR#: _____

Acct#: _____

FINANCIAL AID APPLICATION

Patient Name: _____ **Social Security Number:** _____

Home Address: _____ **Home Phone #:** _____ **Cell #:** _____

City, State, Zip: _____ **Spouse's/Other Employer:** _____

Patient's Employer: _____ **Patient's Date of Birth:** _____

Please list below the additional people living in your home, if needed, please include a separate sheet.

	Name	Social Security Number	Date Of Birth	Relationship to Patient
1.				
2.				
3.				
4.				
5.				
6.				

- Do you have health insurance? If yes, name of health insurance carrier. ___ Y ___ N _____
- Have you applied for insurance through the Health Insurance Marketplace? If yes, submit a copy of the decision statement and enter the date of application. ___ Y ___ N Date of application _____
- Have you applied for Medicaid? If yes, submit a copy of the decision letter. ___ Y ___ N
- Is this visit related to a job-related injury? ___ Y ___ N
- Is this visit related to a motor vehicle crash? ___ Y ___ N

➢ **If you have no income, submit a letter of support. The person who provides your support (food/shelter) must sign the letter.**

➢ **If unemployed, last date of employment: _____. Will you receive unemployment? Please provide an ESC statement reflecting status of benefits.**

INCOME

Patient:		**Spouse/Other Income:**	
Wages/Salaries/Tips	$_____/Month	Wages/Salaries/Tips	$_____/Month
Unemployment/Compensation	$_____/Month	Unemployment/Compensation	$_____/Month
Social Security / SSI Benefits	$_____/Month	Social Security / SSI Benefits	$_____/Month
Pension/Retirement/VA	$_____/Month	Pension/Retirement/VA	$_____/Month
Alimony / Child Support	$_____/Month	Alimony / Child Support	$_____/Month
Other: _____	$_____/Month	Other: _____	$_____/Month

ASSETS

Do you own your home	___ Y	___ N	If yes, payment amount $ _____ /Month	Home value $ _____	
Do you rent your home	___ Y	___ N	Amount: $ _____/Month		
Checking Account	___ Y	___ N	Balance: $ _____		
Savings Account	___ Y	___ N	Balance: $ _____		
Stocks/Bonds/CDs	___ Y	___ N	Value: $ _____		
IRA/401K/403B	___ Y	___ N	Value: $ _____		
Automobile 1	___ Y	___ N	Value: $ _____	Year/Make/Model: _____	
Automobile 2	___ Y	___ N	Value: $ _____	Year/Make/Model: _____	
Boat/Motorcycle/RV	___ Y	___ N	Value: $ _____	Description: _____	
Other: _____			Value: $ _____	Description: _____	
Other Real Estate	___ Y	___ N	Value: $ _____	Payment $ _____ /Month	
				Rental Income $ _____ /Month	

Address _____

Turn this page over to complete other side

PART OF THE PERMANENT MEDICAL RECORD

Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

DOB: _____ MR#: _____

Acct#: _____

FINANCIAL AID APPLICATION

HOUSEHOLD EXPENSES (That YOU are responsible for)

Food:	$_____/Month	Auto Payment 1:	$_____/Month
Heating/Electric:	$_____/Month	Auto Payment 2:	$_____/Month
Phone/Cell:	$_____/Month	Auto Insurance:	$_____/Month
Water/Sewer/Trash:	$_____/Month	Auto Gas/Maintenance:	$_____/Month
Child Care/Child Support:	$_____/Month	Property Taxes/Homeowners Ins:	$_____/Month
Cable/Satellite/Internet:	$_____/Month	Credit Cards:	$_____/Month
Doctors/Medications:	$_____/Month	Loans: _____	$_____/Month
Health/Life/Dental Ins:	$_____/Month	Other: _____	$_____/Month

Please describe your hardship:

_____

_____

_____

_____

I understand that this application is valid only for the individual applying. A separate application is required for any additional person listed in the household that has a current account with NHRMC.

INITIAL _____ **DATE** _____

I understand that this application is only for the Hospital bill. This does not cover the separate bills I will receive from the physicians/doctors that may include the ER doctor, Radiologist, Surgeon, Rehabilitation Doctor, Anesthesiologist, Pathologist, etc. when applicable.

INITIAL _____ **DATE** _____

I certify that the above statements are true and correct to the best of my knowledge and belief. I understand that the Hospital will require PROOF of INCOME (credit report, tax returns, paycheck stubs, disability determination, etc.). I will make applications for any assistance (Medicaid, Medicare, Disability, Insurance, etc.) which may be available for payment of my hospital charges and that I will take any action reasonably necessary to obtain such assistance and will assign or pay to the Hospital the amount recovered for hospital charges. Further, I understand that charity care is not considered an alternative option to other assistance programs. I understand that this application is made for the Hospital to determine my eligibility to have the Hospital accounts transferred to the Financial Aid program by the criteria established.

I authorize New Hanover Regional Medical Center to contact employers, institutions and references of this application to verify its accuracy and to check my credit history to substantiate its validity. I understand that any false information or refusal to supply information will void my request for Financial Aid. I understand that the Hospital may evaluate my financial ability again and take whatever action becomes appropriate. If it is determined that I am eligible to receive Financial Aid or waiver of payment, it is my responsibility to notify the hospital of financial status changes. If you are claimed as a dependent by someone other than yourself, their income and signature will be required to process your application.

_____ _____

Date of Request Applicant's Signature

_____ _____

Application Taken By Signature of Applicant's Spouse/Parent/Other

DO NOT WRITE BELOW THIS LINE

___ Approved F/A ___ Approved One-Time ___ Incomplete

___ Approved E/E/H ___ Referred to Management ___ Denied

Comments:

_____

_____

_____

_____ _____

Patient Financial Services Representative Date

PART OF THE PERMANENT MEDICAL RECORD

2068

Financial Aid Application

Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

DOB: _____ MR#: _____

Acct#: _____

PATIENT ATTESTATION

Attention: Financial Aid
NHRMC P.O. Box 9000 Wilmington NC 28402-9000

Patient Name: _____ Date: _____

Patient Account: _____ Date of Service: _____

1. *I attest that I have no income*:

   Signature of Patient or Responsible Party: _____

2. *I attest that I have no assets*:

   Signature of Patient or Responsible Party: _____

   Spouse Signature: _____

3. A. *I attest that I am homeless and have been since*: Date: _____

   B. *I attest that I am homeless and have no identification since*: Date: _____

   C. *My last known address was*: _____

   Signature of Patient or Responsible Party: _____

   Spouse Signature: _____

4. *I attest that I have no insurance to cover a hospital service*:

   Signature of Patient or Responsible Party: _____

   Spouse Signature: _____

5. *I attest that I have lived in North Carolina for __ months/years and have the intent to remain in North Carolina.*

   My current address in North Carolina is: _____

   Signature of Patient or Responsible Party: _____

6. Do you or your spouse own property in which you do not reside? Yes _____ No _____

   If yes, provide mailing address of property: _____

   Patient Signature: _____

   Spouse Signature: _____

I certify that this information is true and accurate ot the best of my knowledge for the date of service above.

Witness: _____ **Date:** _____

Signature/Credentials: _____ Date: _____ Time: _____

Printed Name: _____

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD