Hugh Chatham Memorial Hospital

Financial Assistance Application

Patient Information	Responsible Party Info	Spouse Information
Name:	Name:	Name:
SS#:	SS#	SS#:
DOB:	DOB:	DOB:

Patient Address		How long at this address?	
		US Citizen? Y/N?	
Phone #			

Marital Status	☐ Single	☐ Separated	☐ Married	☐ Widow	☐ Divorced

Household Family Members **(If family member is employed please send proof of income.)**

Name		Birth Date	Name		Birth Date
Name		Birth Date	Name		Birth Date
Name		Birth Date	Name		Birth Date

Employment History

- **Please provide proof of income. *Examples:* Pay Stub, W2 Form, Tax Return, Social Security or Disability Verification, Letter from Employer, Public Assistance, Retirement Income, Alimony, Child Support or Education Assistance.**
- **If you have no income please provide a letter from person paying your expenses.**
- **If you receive food stamps please provide proof of Food Stamps.**

Patient or Responsible Party's Employer:			From:	To:
Salary	Hr/Wk/Mo/Yr	Average # of hrs worked per week:	Phone #:	
Prior Employer's Name:			From:	To:
Salary	Hr/Wk/Mo/Yr	Average # of hrs worked per week:	Phone #:	
Spouse's Employer:			From:	To:
Salary	Hr/Wk/Mo/Yr	Average # of hrs worked per week:	Phone #:	
Prior Employer's Name:			From:	To:
Salary	Hr/Wk/Mo/Yr	Average # of hrs worked per week:	Phone #:	

If no income, please explain:

Health Insurance

Are you covered by any Insurance? Y/N?	If so, what insurance?

Have you applied for Medicaid? Y/N?		If yes, when:		What County?	
Caseworker's Name:				Approved or Denied for Medicaid?	

Child Support/Alimony *Please provide Proof*	Do you receive Child Support or Alimony? Y/N?		If so, how much?	$_____/Month
Food Stamps *Please provide Proof*	Do you receive Food Stamp assistance? Y/N?		If so, how much?	$_____/Month

Assets **(attach additional pages if necessary)**	
Primary Residence	$
Other Real Estate	$
Bank Accounts	$
Checking	$
Savings	$
Retirement Accounts	$
Stocks/Mutual Funds/Trust	$
Cash Value of Life Ins	$
Monthly Food Stamps	$
Total Assets	$

Liabilities	**Current Bal**	**Mo Payment**
Mortgage Balance(s)	$	$
Rent	$	$
Utilities	$	$
Credit Cards	$	$
Vehicle Loan(s)	$	$
Other:	$	$
	$	$
	$	$
	$	$
Total Debt	$	$

Types of Vehicles

Make		Model		Year	
Make		Model		Year	
Make		Model		Year	

Certification

I certify that the above information is correct to the best of my knowledge. I authorize the release of any of this information from my employer and or holders of this information, for the purpose of evaluating assistance in the payment of my medical bills and verification of my income, expenses and assets.

Patient /Guarantor Signature	Date	
Interviewer's Signature	Date	

Return Completed form & Proof of Income to: Hugh Chatham Memorial Hospital
P.O. Box 560
Elkin, NC 28621
Attention: Financial Assistance

REMINDER: Please send proof of income with completed application.

Examples*:* Pay Stub, W2 Form, Tax Return, Social Security or Disability Verification, Letter from Employer, Public Assistance, Retirement Income, Alimony, Child Support, Education Assistance and Food Stamps. If you have no income send letter by person paying your expenses.