

Hospital Sponsored Financial Assistance Application

FAP is a financial assistance program for patients who receive services at Cape Fear Valley Health. Eligibility is based on family size and household income as compared to the federal poverty guidelines.

Please fill out all information completely to prevent any delays in processing your application.

Patient Information			
Patient Name	Last 4 of Social Security #	Date of Birth	Account #
		Home Phone #	Mobile Phone #

Guarantor Information				
Guarantor Name	Relationship to Patient	Social Security #	Date of Birth	Marital Status
Address	•	City, State and Zip		•
Employer	Hours Per Week	Hourly Pay	Work Phone#	
Spouses Employer	Hours Per Week	Hourly Pay	Work Phone#	

Note: If the address where you receive mail is different from the address where you live, please fill out the "mailing address" information below

Mailing Address		City, State and Zip			
Health Insurance Informatior	1		Check this box if the patient do	es not have any source of	health coverage
Health Insurance	Subscriber		Policy #	Group #	Effective Date
Has a memer of the household lost t	their job within the last 60 days?			Yes	No
Did he/she receive a COBRA election	n notice?			Yes	No
Did he/she elect COBRA coverage?		Yes	No		
If he/she did not elect COBRA cover	age, why?				ļ
Has he/she applied for Medicaid?				Yes	No

Please List All Household Members Below				
Name	Age	Last 4 of Social Security #	Relationship to Patient	

Monthly Household Income				
Type of Income	Guarantor Monthly Gross Income	Spouse's Monthly Gross Income		
Regular Wages	\$	\$		
Retirement/Pension/Social Security Retirement	\$	\$		
Disability	\$	\$		
Unemployement	\$	\$		
Child Support/Alimony	\$	\$		
Workers Compensation	\$	\$		
Other:	\$	\$		

Supporting Documentation				
Document Type	0	Guarantor	S	pouses
	Provided	Not-Provided	Provided	Not-Provided
Current Bank Statement				
Last Two Pays Stubs				
Proof of Any Other Income Listed Above (if direct deposit bank statement can be used)				
Copy of most recent tax return				
Disability Statement-If Applied or Receiving Disability				
Unemployment Statement-If Applied or Receiving Unemployement				
Social Security Statement - If receiving Social Security				
Self Employed - Tax Return				
Patient is Deceased - Death Certificate and Estate Info if Applicable				

* Applications will not be processed if all information is not provided

Statement of Support		
I certify that I have been unemployed for the last	years/	months. As a result of being unemployed, I receive food, shelter and clothes
from	(relationship to	applicant)

Acknowledgement of Signatures		
I hereby certify that the inforamtion provided in the application is true, accurate and complete to the best of my knowledge. I hereby authorize the hospital to contact any person, firm or organzation to verify any of the information given and I hereby authorize any such person, firm or organization to release to the hospital any financial information it may request.		
Applicant Signature	Date	

To be used by Patient Financial Services Department Only			
Date Received:			
Income Verified: Y/N			
Application Amount:			
Application Status: Approved/Denied	If Denied, why?		
Amount Adjusted to FA:	Amount due from Responsible Party:		
Authorizing party sign and date:			