RETURN YOUR CHARITY APPLICATION ALONG WITH **PROOF OF INCOME**

THE APPLICATION **WILL NOT** BE PROCESSED WITHOUT THIS INFORMATION!

IF MARRIED, WILL NEED SPOUSE'S INFO AS WELL

YOU MUST PROVIDE:

- Current Bank Statement **and** Last 2 Pay Stubs
- Other income accepted:
  - Social Security Statement
  - Copy of Income Tax Return
  - Print your earnings by visiting www.socialsecurity.gov
  - Disability Statement
  - Unemployment Statement

Self Employment: Bank Statement and Complete Tax Return with **ALL** Schedules.

Unemployed: Letter of Support from relatives/friends who is providing you with assistance. **ALSO**, include a bank statement, income tax return and print your earnings from www.socialsecurity.gov

If you have any questions regarding this application, please call 910-615-7070.

CAPE FEAR VALLEY®

TRANSFORMING HEALTHCARE™

Application for Hospital Sponsored Charity

A. FAMILY INFORMATION:

PATIENT NAME: _____ ACCOUNT #: _____

PATIENT ADDRESS: _____ SOC. SEC. #: _____

GUARANTOR NAME: _____ GUARANTOR SOC. SEC. #: _____

GUARANTOR ADDRESS: _____ TELEPHONE #: _____

NUMBER OF DEPENDENTS BY NAME AND AGES: _____

_____

B. EMPLOYMENT INFORMATION:

GUARANTOR EMPLOYER: _____ HOURS PER WEEK: _____

HOURLY WAGE: _____

SPOUSE EMPLOYER: _____ HOURS PER WEEK: _____

HOURLY WAGE: _____

TOTAL INCOME: _____

C. OTHER INCOME:

SOCIAL SECURITY: _____

CHILD SUPPORT: _____

PENSION: _____

UNEMPLOYMENT: _____

DISABILITY: _____

WORKERS COMPENSATION: _____

OTHER: _____

TOTAL INCOME: _____

I HAVE APPLIED FOR ASSISTANCE THROUGH THE FOLLOWING PROGRAMS AND WAS FOUND TO BE INELIGIBLE FOR ASSISTANCE:

HCI: _____ WELFARE/MEDICAID: _____ TRUSTEES: _____

DISABILITY: _____ OTHER: _____

VERIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

I understand that the statements I have made on this form are subject to investigation and verifications. I understand that I am required Proof of the information which I have given on this form, and I agree to help CFVMC obtain the necessary verifications. I hereby authorize the release of wage information, financial information from banks and other financial institutions and from the Department of Health and Human Services to CFVMC.

PATIENT/GUARANTOR SIGNATURE: _____ **DATE:** _____

To be used by Patient Financial Services

Date Received: _____

Income Verified: _____ (Y / N)

Application Approved: _____

Application Denied: _____

Application Amount: $_____

Amount Approved For Charity: $_____

Amount due from Patient/Resp. Party $_____

Reason Denied: _____

_____

Authorized By: _____ _____

Hospital Representative Signature Date