CAPE FEAR VALLEY HEALTH

# 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 Information** ☐ Check this box if the patient does not have any source of health coverage | | | | |
|---|---|---|---|---|
| Health Insurance | Subscriber | Policy # | Group # | Effective Date |
| Has a memer of the household lost their job within the last 60 days? | | | Yes | No |
| Did he/she receive a COBRA election notice? | | | Yes | No |
| Did he/she elect COBRA coverage? | | | Yes | No |
| If he/she did not elect COBRA coverage, why? | | | | |
| 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 | $ | $ |
| Disability | $ | $ |
| Unemployement | $ | $ |

| | | |
|---|---|---|
| Child Support/ Alimony | $ | $ |
| Worker's Compensation | $ | $ |
| Other: | $ | $ |

| **Supporting Documentation** | | | | |
|---|---|---|---|---|
| Document Type | Guarantor | | Spouses | |
| | 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 information 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 organization 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. I am aware that any guarantor payments made on accounts where financial assistance is applied will not be refunded. | |
| 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: | | |