FINANCIAL ASSISTANCE APPLICATION
(For North Carolina Residents Only)

Thank You for choosing CaroMont Health for your medical needs. We strive to provide quality care to meet the needs of all people in the community we serve. For those individuals who feel they are unable to pay for the services rendered, we accept applications for financial assistance.

Please complete the requested information below:

Patient Information:

Patient's Name: _____

Date of Birth: _____

Account #_____

Social Security #:_____

If No SS #, Please Provide Copy of Birth Certificate

Marital Status: _____ If Married, Name & SS # of Spouse:
_____

If Minor (under 18), Name & SS # of Responsible Party:
_____

Address: _____

Telephone #: Home: _____

Cell: _____Other:_____

Number of dependents in home: _____ Ages of dependents:

#1_____ #2_____ #3 _____ #4_____ #5 _____ #6_____

Primary Source of Income:

Name of Employer: _____

Telephone #:_____

Amount of Income: $_____ (Week) $_____ (Month) _____(Year)

*If currently unemployed, name & date of last employment:*_____

Source of 2nd Income (Spouse):

Name of Employer: _____

Telephone #:_____

Amount of 2nd Income: $_____ (Week) $_____(Month) $_____(Year)

If spouse is currently unemployed, name & date of last employment:
_____

Other Sources of Income:

- Child Support/Alimony: $_____
- Social Security Benefits: $_____
- Pension/Retirement: $_____
- VA Benefits: $_____
- Unemployment Benefits: $_____
- Other: $_____

Expenses: (please send copies)

- Rent: $_____
- Mortgage: $_____
- Electricity: $_____
- Water: $_____

- Other: $_____

Verification of yearly gross income is required to be considered for this program. Please provide **ONE** of the following forms of documentation that relates to your situation:

- ✓ Latest payroll stub (required for both patient and spouse if both in household)
- ✓ Bank statements
- ✓ W-2 from last year (if employed)
- ✓ Tax return completed by an Accountant from last year (if self employed)
- ✓ Statement of Social Security Benefits
- ✓ If unemployed, letter from friend or relative stating you live with them

Additional information may be requested for final decisions.

Please complete and sign this application and return with one form of documentation listed above.

I certify that the above information is true and correct. I authorize CaroMont Health to verify the information I have provided.

Signature Date