FirstHealth OF THE CAROLINAS

PLEASE MAIL OR FAX COMPLETED FORM AND SUPPORTING DOCUMENTATION TO:

FIRSTHEALTH OF THE CAROLINAS
PATIENT ACCOUNTS
P.O. BOX 3000
PINEHURST, NC 28374
FAX: (910) 235-7830

FOR QUESTIONS, PLEASE CALL (800) 798-6946 OR (910) 715-1010. TO ACCESS THIS FORM ONLINE GO TO www.firsthealth.org/paymybill

APPLICATION FOR FINANCIAL ASSISTANCE

I. PATIENT INFORMATION

PATIENT NAME:	ACCOUNT NUMBER:
ADDRESS:	BIRTH DATE:
CITY, STATE, ZIP:	
EMAIL ADDRESS:	PHONE:
MARITAL STATUS: (CHECK ONE) ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED	

II. FINANCIAL INFORMATION

INCLUDE GUARANTOR, SELF, SPOUSE AND DEPENDENTS CLAIMED ON TAXES	DATE OF BIRTH	RELATION TO PATIENT	MONTHLY GROSS INCOME	SOURCE OF INCOME
TOTAL MONTHLY GROSS INCOME:			$	☐ **CALCULATE TOTAL**

IF YOU DO NOT HAVE MONTHLY WAGES LISTED ABOVE, PLEASE EXPLAIN HOW YOU TAKE CARE OF YOUR MONTHLY LIVING EXPENSES:

IF UNEMPLOYED, PROVIDE THE DATE EMPLOYMENT ENDED _____ HAVE YOU APPLIED FOR UNEMPLOYMENT or COBRA? ☐ **YES** ☐ **NO**

HAVE YOU APPLIED/BEEN APPROVED FOR MEDICAID OR DISABILITY? ☐ **YES** ☐ **NO** NAME OF CASE WORKER/COUNTY:_____

WAS YOUR SERVICE AT FIRSTHEALTH THE RESULT OF AN ACCIDENT? ☐ **YES** ☐ **NO**

II. FINANCIAL INFORMATION (continued)

CHECKING ACCOUNT? ☐ YES ☐NO	BANK NAME: LOCATION:	ACCOUNT BALANCE: $
SAVINGS ACCOUNT? ☐ YES ☐NO	BANK NAME: LOCATION:	ACCOUNT BALANCE: $
STOCKS, BONDS, IRA'S, 401K, CD, ETC.? ☐YES ☐NO	BANK NAME: LOCATION:	ACCOUNT BALANCE: $

DO YOU ☐**RENT** ☐**OWN** YOUR PRIMARY RESIDENCE? MONTHLY PAYMENT (RENT OR MORTGAGE): $_____

IF YOU OWN, PROVIDE VALUE OF PRIMARY RESIDENCE (DOCUMENTATION NOT REQUIRED): $_____

DO YOU OWN OTHER REAL ESTATE PROPERTY?☐**YES** ☐**NO** IF YES, PROVIDE VALUE: $_____

DO YOU OWN PERSONAL PROPERTY?☐**YES** ☐**NO** LIST ALL CARS, BOATS, TRUCKS, MOTORCYCLES, CAMPERS, MOBILE HOMES, ETC.

ITEM:	MAKE / MODEL:	YEAR:	MTHLY PAYMENT: $	VALUE: $
ITEM:	MAKE / MODEL:	YEAR:	MTHLY PAYMENT: $	VALUE: $
ITEM:	MAKE / MODEL:	YEAR:	MTHLY PAYMENT: $	VALUE: $

PROVIDE ANY OTHER INFORMATION SUPPORTING YOUR FINANCIAL POSITION, OR DESCRIBE ANY FINANCIAL HARDSHIPS:

I CERTIFY THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE, ACCURATE AND TRUE. I UNDERSTAND THAT FRAUDULENT OR MISLEADING INFORMATION WILL MAKE ME INELIGIBLE FOR FINANCIAL ASSISTANCE. I AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED BY FIRSTHEALTH TO VERIFY THE INFORMATION PROVIDED. SHOULD I BE REFERRED TO A FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM, I AUTHORIZE FIRSTHEALTH TO RELEASE AND OBTAIN ALL INFORMATION NEEDED TO DETERMINE ELIGIBLITY FOR THAT FUNDING.

APPLICANT SIGNATURE:	DATE:

IN ORDER FOR FIRSTHEALTH OF THE CAROLINAS TO COMPLY WITH STATE AND FEDERAL GUIDELINES, EACH OF THE ITEMS LISTED ON THIS APPLICATION NEEDS TO BE COMPLETED AND REQUIRES PROOF OF DOCUMENTATION. YOUR APPLICATION WILL BE DELAYED AND YOUR ACCOUNT(S) WILL PROGRESS THROUGH OUR COLLECTION CYCLE UNTIL ALL DOCUMENTATION IS RECEIVED.

THE FOLLOWING ARE EXAMPLES OF DOCUMENTS THAT ARE NEEDED BASED ON YOUR RESPONSES IN THE APPLICATION (please submit copies only):

- PAY CHECK STUBS or your most recent FEDERAL INCOME TAX RETURN
- LETTER or BANK STATEMENT verifying Social Security, SSI or other Government Benefits received
- BANK STATEMENTS for Checking, Savings, or Investment Accounts
- TAX STATEMENTS showing value of Real Estate and Personal Property (EXCLUDING PRIMARY RESIDENCE)