NORTHERN
REGIONAL HOSPITAL

Dear Applicant,

To be considered for Northern Regional Hospital's Charity Care, it is important that you complete all requested information on the application and sign where indicated. Incomplete applications will delay the application process, so please ensure all requested information is provided and is correct.

Northern Regional Hospital's Charity Care policy DOES NOT cover the following services: Labor & Delivery Services, Outpatient Therapy, Outpatient Labs, Lab work sent to Northern Regional Hospital from a Northern Regional Hospital Physician Office, Pain Management, Weight Loss, Screening Colonoscopy, Circumcisions, or elective services.

OR/Day Surgery services will be reviewed on a case by case basis by the Practice Manger, in consultation with the provider, to determine if they are urgent/emergent. Only urgent/emergent procedures will be considered for charity care.

All Inpatient stays and ER visits are eligible for Charity Care. Any other services will be reviewed on a case by case basis.

Requirements:

- Patient must reside in Northern Regional Hospital's primary service area as defined in policy
- Patient must be uninsured or covered by Medicare, Medicare Advantage, Medicaid or Medicaid Advantage
- Household income must be at or below 200% of the Federal Poverty Guidelines
- Patient must have been screened for Medicaid or other coverage (MedData can screen for Medicaid)
- Must fall within household asset limits defined in policy.
- Patient must provide all requested documentation with completed and signed application.

Proof of current income for all Household members:

- If working, we will need 3 months of pay stubs
- If you do not have a source of income, you will need to have a Letter of Support filled out by the person who pays your bills, along with copies of the monthly bills they pay.
- If you have Retirement/Pension Income, we will need a statement for the current year.
- If you have Social Security or Social Security Disability income – We need a copy of your current year's letter or copy of bank statements showing direct deposit amount.
- If you are receiving VA benefits, workers comp or short-term disability, we will need proof of what you are receiving in the current year.
- If you are unemployed, we will need proof of Employment Security Commission unemployment benefits.
- Copy of most recent year's federal income tax return.
- If you receive Alimony or Child Support copy of legal agreement.
- If you receive Food Stamps, we will need a copy of the approval letter with approved amount.

SUBMIT COMPLETED APPLICATION AND DOCUMENTATION TO THE FOLLOWING:

Northern Regional Hospital
830 Rockford Street
Mt. Airy, NC 27030

If you have any questions, please call Customer Service at 336-719-7458.

NORTHERN REGIONAL HOSPITAL

Financial Assistance Application

Location: ☐ Hospital
☐ Physician Practice: _____

PATIENT INFORMATION:

Patient Name: SS#: Date of Birth:

Is Patient Covered by Health Insurance? Y or N_____ If yes, what Insurance? _____

Patient Screened by MedData? Y or N ____ If no, send to MedData Why didn't Patient meet MCD Criteria?_____

Has patient Applied for Medicaid? Y or N_____ If Yes, when?_____ What County? _____

Who was the Caseworker? _____Was Medicaid Approved, Denied or Pending? _____

If you applied for Medicaid, you must provide proof of approval or denial

RESPONSIBLE PARTY INFORMATION: Resp. Party has accounts to be considered? Yes No

Responsible Party Name: Relationship to Patient: Phone #
( ) -

Address: How long at this address?

Social Security #: Date of Birth: Marital Status: ____Single ____Married ____Widow
____Divorced ____ Separated

Employer's Name: How long have you Worked here? _____

Employer's Phone #: Full Time or Part Time?_____ Hours/Week?_____

Total Income *(All Sources including Social Security/Retirement)* Other Sources of Income:

Yearly :$_____ or Monthly $_____ Monthly Child Support/Alimony? $_____

or Hourly Rate $_____ @ _____Hours/week Monthly Food Stamps? $_____

PROOF OF INCOME IS REQUIRED- Copy of W-2, Most recent Tax Return, Social Security, Child Support/Alimony, & Food Stamps

2nd RESPONSIBLE PARTY (SPOUSE) INFORMATION: Resp. Party has accounts to be considered? Yes☐ No☐

Responsible Party Name: Relationship to Patient : Phone # :
( ) -

Address: How long at this address?

Social Security #: | Date of Birth: | Marital Status: ____Single ____Married ____Widow
____Divorced ____ Separated

Employer's Name: How long have you Worked here? _____

Employer's Phone #: Full Time or Part Time?_____ Hours/Week?_____

Total Income *(All Sources including Social Security/Retirement)*

Yearly :$_____ or Monthly $_____

or Hourly Rate $_____ @ _____Hours/week

Other Sources of Income:

Monthly Child Support/Alimony? $_____

Monthly Food Stamps? $_____

PROOF OF INCOME IS REQUIRED- Copy of W-2, Most recent Tax Return, Social Security, Child Support/Alimony, & Food Stamps

Household Family Members - List everyone living in the home.

If family member is employed you are required to send proof of income for them also

Acceptable Proof of income: Copy of W-2, Most recent Tax Return, Social Security, Child Support/Alimony, & Food Stamps

Name:	Date of Birth:	Relationship to patient:	Work? Y/N	Annual Income:	Accounts to Consider? Y/N

Assets (You are required to provide copies of bank statements)	
Savings Account Balance	$
Checking Account Balance	$
Investments	$
Other:	$
TOTAL ASSETS	$

Monthly Bills (You are required to provide copies of bills)	**Monthly Payment**
Home Loan/Rent	$
Home Owners Insurance	$
Electric/Gas Bill	$
Water Bill	$
Car Loan(s)	$
Car Insurance	$
Cell/Home Phone Bill	$
Cable/Satellite Bill	$
Medical Bills	$
Pharmacy	$
Other:	$
TOTAL MONTHLY PAYMENTS	$

I certify that the above information is correct to the best of my knowledge. I authorize the release of any of this information from my employer and or holders of this information, for the purpose of evaluating assistance in the payment of my medical bills and verification of my income, expenses and assets. I understand I am responsible for making monthly payments until my application is approved.

Patient /Guarantor Signature	Date	

Return Completed form to: **Northern Regional Hospital, Attn: Customer Service**
830 Rockford Street
Mt. Airy, NC 27030
Ph# 336-719-7458

DON'T FORGET to send proof of income, copies of bank statements, and copies of monthly bills. Applications will not be processed without appropriate documentation.
Acceptable proof of Income: W-2 Form, Most Recent Tax Return, Social Security or Disability Verification, Retirement Income, Alimony, Child Support/Alimony, Education Assistance and Food Stamps. If you have no income send letter by person paying your expenses.

NORTHERN REGIONAL HOSPITAL

LETTER OF SUPPORT

Please have a family member or friend to complete if you have no income. If family member lives at same address as you, we will need proof of their income & copies of their monthly bills.

I, _____, provide the following support to

(Patient name)_____. .

(Check all that apply)	$ Amount/Month
o Housing/Rent/Mortgage	$_____
o Food	$_____
o Utilities (Electric/Water)	$_____
o Car	$_____
o Clothing/Toiletries	$_____
o Gas	$_____
o Cash	$_____

o Other:_____

Additional Comments:

_____

If you have any questions, please contact me at:

Address:_____ Phone#_____

Relationship to patient: _____

Signature of Family Member/Friend_____ Date _____