NOVANT HEALTH

For Office Use Only
Patient Type _____
Amount of W/O $_____
S/A Results: _____h/h $ _____
Facility _____
Account #_____
Med. Rec.#

I. Patient Demographics

Patient Name: _____
(Last) (First) (Middle)

_____
(SSN) (DOB)

Guarantor Name: _____
(Last) (First) (Middle) (SSN) (DOB)

Address: _____
(Street) (City) (State) (Zip Code)

_____
(Phone)

Have you applied for Financial Assistance with any Novant Health, Inc. facility (e.g. Novant Medical Group, Presbyterian Hospital, Brunswick Community Hospital, Thomasville Medical Center, Forsyth Medical Center, etc.) in the past?_____ Yes _____ No.
If yes, date of application or approval? _____

II. Household Information

Marital Status (Circle One)	Married	Single	Separated	Total in Household

Dependent Name(s)	Dependent Date of Birth

III. Employment/Income

Patient/Guarantor Employer:
Gross Monthly Income Amount $
Income Source-*Please attach verification or explanation of current situation*
Spouse or other Income Source and Gross Monthly Amount $
Total Annual Gross Household Income $
If no income, how do you support yourself?

Do you have an active bank account?	Did you file taxes for the prior year?

IV. Insurance Verification

Does your employer offer health insurance	YES	NO
Do you have any health insurance	YES	NO
Name of Insurance Company:		
Are you employed?	YES	NO

If you have become unemployed within the last 90 days, please provide:

The name of your last employer and dates of employment:

Give the name of your employer sponsored insurance carrier:

Are you eligible for COBRA Benefits?

I certify that the information provided is true and to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I authorize the release of any information needed to verify the information provided and for billing and collections in compliance with applicable federal and state laws. Proof of income may be required before any consideration is made. Acceptable proof of income maybe but not limited to: copy of paycheck stubs, copy of last year's tax return, or letter from employer stating present salary and hours worked.

Signature Patient/Guarantor:	*Date:*
% Federal Poverty Level:	Decision Based On:
Comments/Summary:	

Signature of Interviewer		Date:		
Signature of Manager		Date:	Approved	Denied
Signature of Director		Date:	Approved	Denied
Signature of EVP/VP		Date:	Approved	Denied

Mail Completed Application to: Novant Health, ATTN: Financial Assistance, PO BOX 11549, Winston Salem, NC 27116