



## Financial Assistance Required Documentation

- Valid, current **IDENTIFICATION:**
  - State or Federal issued Photo I.D. (driver's license, state ID, Green Card, passport)
  - Proof of residence (2 required; i.e., phone or utility bill, rent receipts/lease, trash, cable)
  
- INCOME** (Please provide all income for everyone residing in the household) for the last 90 days:
  - Complete **FEDERAL TAX** information from the last year
  - IRS form W-2
  - Paycheck Stubs or notarized letter from employer that includes your wages per hour and hours worked per week
  - Social Security award letter stating current amount being received from Social Security
  - Proof of payments from pension plans
  - Proof of unemployment benefits (UIB), if applicable for patient and spouse
  - If self-employed, submit a Profit and Loss report for each month for the past 3 months
  - If the patient is not working, notarized letter of survival (how you are living) from the person(s) supporting the patient who is requesting financial assistance
  
- BANK/CREDIT UNION STATEMENTS** from the last 3 months on all accounts:
  - Checking
  - Savings
  - Investments, including stocks and bonds
  - Trust funds
  - Money market accounts
  - Mutual funds
  - Other investment funds that will not incur a penalty for early withdrawal
  
- INSURANCE VERIFICATION:**
  - A copy of all current insurance cards, including Medicare, Medicaid, and CACP, or a letter stating you choose not to carry health insurance.
  - A copy of any other discount program cards, such as Doctor's Care, healthcare co-op, cost-sharing health plans, etc.
  - Acceptance letter into any other external charity program for medical expenses
  - Any crowd-funding websites, social media accounts, or bank-sponsored charity/gift funds set up to solicit funds to pay for expenses.

Applicant Demographics				
First Name:		Last Name:		MI:
Street Address:			City:	
Date of Birth:				
State:	Zip Code:	Account#	SSN#	

Household Information Please fill in the information for all members of your household (self, spouse, children, other dependents)					
Name	DOB	Relationship	SSN	Driver's License/ID #	Phone Number

Household Income Please list all sources of income coming into the household		
Income Type	Who receives this income	Gross Monthly Amount
Self-Employment		
Wages, Tips, Commissions		
Other Unearned Income (Please indicate Source)		
Pension Income		
Property Rental Income		
SSDI/RSDI Income		
SSI Income		
Unemployment Income		
VA Benefits		
Workers Compensation		
Total:		

<b>Household Assets</b> Please list all assets owned by any household member		
Asset Type	Who receives this Asset	Gross Monthly Asset
Checking Account		
Savings Account		
Investments, including stock and bonds		
Trust funds		
Money Market accounts		
Mutual funds		
Other investment funds that will not incur a penalty		
Total:		

I am applying for Financial Assistance for health care services rendered at Centura Health. I hereby certify that the above information is true and correct to the best of my knowledge. I also understand that the appropriate documents must be provided and/or mailed with this application for consideration of Financial Assistance.

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Signature of Patient, Spouse, or Legal Representative

\_\_\_\_\_  
Date