Centura Health

FINANCIAL ASSISTANCE—SPECIAL CHARITY/SLIDING FEE SCALE APPLICATION

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:		

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

Effective 03/01/2018