MARIA PARHAM
HEALTH

Duke LifePoint Healthcare

Financial Assistance Application

1. Patient Information

Patient's Name: _____
First M.I. Last

Patient's Address: _____
Street City State / Zip Code

Patient's Phone Number: _____

Patient's Date of Birth: _____

Patient's Account Number: _____

2. Guarantor Information

Guarantor's Name: _____
First M.I. Last

Guarantor's Address: _____
Street City State / Zip Code

Guarantor's Phone Number: _____

Guarantor's Date of Birth: _____

3. Household Information

Dependents

Name	Date of Birth=

Employment and Insurance Information: Insurance Status is not an eligibility factor

	Patient/Guarantor	Other
Name of employer (If unemployed, write “none”)		
Are you in school? (If yes, write name of school)		
Do you have health insurance? (Y/N)		
If no, is health insurance available through your employer or school? (Y/N)		
Do you have Medicare? (Y/N)		
Do you have Medicaid? (Y/N)		
Do you receive Veteran’s Benefits? (Y/N)		

Total Household Income

Please note your household’s total monthly income from all sources:

□ Wages	$_____	□ Tips	$_____
□ Self-Employment	$_____	□ Business Profits	$_____
□ Interest Income	$_____	□ Dividends	$_____
□ SSI/Social Security	$_____	□ Rental Income	$_____
□ Child Support	$_____	□ Alimony	$_____
□ Veteran’s Benefits	$_____	□ Worker’s Comp.	$_____
□ Unemployment	$_____		
□ Pension/Retirement	$_____	□ Farm Income	$_____
□ Insurance/Annuities	$_____	□ Other	$_____
□ Trust Income	$_____		

4. Required Documentation

Attach copies of the documents listed below for both the patient/guarantor and other (please submit only copies; no original documents):

- Most recent tax return, including W-2 forms and supporting schedules
- Last 2 pay stubs or a letter from an employer verifying income (include employer’s phone number and address)
- Written verification of any other income received (e.g. child support, social security, alimony)

OR

- **If you have no income, a letter or a comment below from you stating your source for paying living expenses**

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5. Other Comments

6. Acknowledgement

I hereby acknowledge that the information in this application (including any attachments) is true, complete and accurate to the best of my knowledge. Furthermore, I understand that other available payments sources will be exhausted.

I hereby authorize **Maria Parham Health** to contact any person, firm or organization to verify any of the information given, and I hereby authorize any such person, firm or organization to release such information to **Maria Parham Health**.

Patient/Guarantor's Signature: _____
Date

Other's Signature: _____
Date

7. Mailing Instructions / Contact Information

Mail (or hand deliver) your complete Financial Assistance Application with documentation to:

Maria Parham Health
Attn: Financial Counselors
566 Ruin Creek Road
Henderson, NC 27536

For additional information about **Maria Parham Health**'s Financial Assistance Policy, or for assistance with this application, please call Patient Financial Services at **252-436-1863** or visit a Financial Counselor at the above address.

Please allow 30 days for processing.

For Internal Use Only

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HEALTH

Duke LifePoint Healthcare

Processed By: _____ Date: _____
Financial Counselor

Eligibility Determination: ( ) Yes ( ) No Discount: _____%

If denied, state reason: _____

Reviewed/Approved By: _____ Date: _____
Patient Access Manager/Director (or designee)

_____ Date: _____
Patient Financial Services Director (or designee)

_____ Date: _____
Hospital Controller/CFO (or designee)

566 Ruin Creek Road • P.O. Box 59 • Henderson, NC 27536
(252) 438-4143 • www.mariaparham.com

MARIA PARHAM
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Instructions for Completing Maria Parham Medical Center Financial Assistance Application

1. Patient Information

Patient's Name: Clearly print on the blank line the first name, middle initial, and last name of the patient.

Patient's Address: Clearly print on the blank line the address where the patient lives including the city, state and zip.
Patient's Phone Number: Clearly print on the blank line the patient's phone number.
Patient's Date of Birth: Clearly print on the blank line the patient's date of birth.
Patient's Account Number: Clearly print the medical record number **Maria Parham Health** has issued the patient (or the Guarantor's ID # if the application is for a dependent's balances).

2. Guarantor Information (Complete if applicable)

Guarantor's Name: Clearly print on the blank line the first name, middle initial, and last name of the patient's parent, legal guardian or other responsible person ("guarantor").

Guarantor's Address: Clearly print on the blank line the address where the guarantor lives including the city, state and zip.
Guarantor's Phone Number: Clearly print on the blank line the guarantor's phone number.
Guarantor's Date of Birth: Clearly print on the blank line the guarantor's date of birth.

3. Household Information

Dependents: Clearly print the name and date of birth for each person in your household whom you can claim as a dependent on your taxes (children or adults for whom you financially provide more than 50% of their living expenses). You may attach additional sheets of paper if more space is needed.

Employment and Insurance Information: For both patient/guarantor and your other, answer each of the questions indicated. Write "Yes" or "No" or provide the requested information in each applicable box. Insurance status is not an eligibility factor.

Total Household Income: Clearly print the total income your household (yourself, your other, and dependents) receives each month from all sources. You may attach additional sheets of paper if more space is needed. *
FAMILY INCOME: A group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together, all such people (including related subfamily members) are considered as members of one family.
Income includes: earnings, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.

- If your household receives income from a source that you do not see listed, please indicate that amount on the line for "Other."

- If your household receives income from a source that is not paid to you every month, take the total amount you have received from that source during the past 12 months, divide it by 12, and then indicate that amount on the application.

4. Required Documentation

The documents listed in this section are needed to help us determine if you qualify for financial assistance under **Maria Parham Health**'s Financial Assistance Policy. If you do not have, or cannot produce the items listed, please include an explanation as to why. Please note that additional information or documentation may be requested by the Patient Financial Services staff when processing your application.

5. Comments

Use this section to share any additional information you would like us to consider in the evaluation of your Financial Assistance Application.

6. Acknowledgement

Patient/Guarantor's Signature: Carefully read the acknowledgement statement in this section and then sign and date the application.

Other's Signature: Have your other carefully read the acknowledgement statement in this section and then sign and date the application.

7. Eligibility

The information that an individual requesting Financial Assistance has provided will be re-evaluated, verified, and required to be updated at each subsequent time Eligible Services are provided that is more than twelve (12) months after the time such information was previously provided. If such information does change or additional information is discovered relevant to the patient's eligibility for Financial Assistance, it is the patient's responsibility to notify Maria Parham Women's Care at 252-492-8576.