NASH
UNC HEALTH CARE

FINANCIAL SCREENING APPLICATION

REQUIRED INFORMATION: To be considered for financial assistance, extension of time/reduced payment amount for medically necessary services, this confidential statement must be completed. To be considered complete, all questions must be answered, the form must be signed and verification of your household income *before* taxes, and verification of banking statements must be attached. Please send your most recent entire/complete Federal Tax Return and copies of all other income statements. If you do not file federal taxes, you must explain why and who is supporting you financially on page 2 in the additional comments field.

PATIENT NAME_____PATIENT MEDICAL RECORD_____

MARITAL STATUS_____ _____SOCIAL SECURITY#_____DATE OF BIRTH_____

GUARANTOR INFORMATION (Patient or Person/Parent responsible for Bill if patient is a minor)

Last Name_____ First_____ M.I._____ Social Security#_____

Relationship to Patient_____Phone#_____ Email:_____

Street Address_____City_____State____Zip_____County_____

Present Employer_____Phone_____Dates of Employment _____
Business Address_____Position/Job Title_____
Previous Employer (if within last 12 months)_____Dates of Employment_____
Address_____Phone_____Position/Job Title_____

PATIENT'S OR GUARANTOR'S SPOUSE _____ SSN_____
Spouse's Employer_____Dates of employment_____
Employer's address_____Phone_____Position/Job Title_____
Previous Employer (if within last 12 months)_____Dates of Employment_____
Address_____Phone_____Position/Job Title_____

Other Eligible Dependents (Patient's children if under 18 years of age)

First Name	**Last Name**	**Relationship to Guarantor**	**Date of Birth**	**Social Security #**

Property/Real Estate—Must attach copy of County Tax Value Statement
Home: Rent_____ Own_____ Buying_____ Monthly Payment $_____ Home Tax Value_____
Mobile Home: Rent_____ Lot Rent_____ Own_____ Buying_____ Monthly payment _____Tax Value_____
Mortgage lender or landlord_____
Other Real Estate Owned (give description and tax value)_____

Self Employment/Business (Must furnish Federal Tax Return)
Describe Self Employment/Business_____
Business Ownership Real Estate_____ Business Ownership Equity_____

NASH
UNC HEALTH CARE

FINANCIAL SCREENING APPLICATION

INCOME BEFORE TAXES-ATTACH VERIFICATION (For last 6 months)	**MONTHLY INCOME**	**ASSETS-VERIFICATION MUST BE ATTACHED**	**ASSET AMOUNT**
Guarantor's monthly income (before taxes)		**Family Bank Accounts-Statement required**	
Hourly wage_____ Hours per week_____		Bank name/Checking Account Balance	
Previous Income(within last 12 months)			
Hourly wage_____ Hours per week_____		Bank name/Savings Account Balance	
Spouse's monthly Income (before taxes)			
Hourly wage_____ Hours per week_____		401K	
Previous Income (within last 12 months)		Stocks	
Hourly wage_____ Hours per week_____		Bonds	
Income for Guarantor or Spouse:		Certificates of Deposit	
Unemployment Benefits		Commercial Property	
Workman's Comp. Benefits		403B	
Student Loans		IRA	
Retirement Pension Other than Soc.Sec.		Cash Value of Life Ins.(copy of policy req'd)	
Social Sec.(Aged, Disability, or Widow's)			
Children's Social Security		Additional Listing of Property (excluding primary residence)	
Supplemental Security Income (SSI)			
Children's SSI			
Veteran's Benefits			
Alimony			
Child Support			
AFDC/Social Services Assistance			
Food Stamps			
Interest/Dividends			
Income from Rental Property			
Farm/Business Income (Tax Return required)			
Other:			
TOTAL MONTHLY INCOME			
ANNUALIZE INCOME (mthly amount x 12) (A)		TOTAL ASSETS (B)	

I certify that the answers written above and any additional information and/or income/expenses that I have listed on a separate sheet are true 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. I give my social security number voluntarily and have the permission to give the social security numbers of the others provided. The social security numbers may be used for the purpose of accurate identification, filing insurance claims, billing, collections and compliance with federal and state laws. I understand this information must be updated annually to be considered for financial assistance.

I WOULD LIKE TO REQUEST A MONTHLY PAYMENT OF $_____

_____ _____

Patient or Guarantor Date

RETURN INFORMATION TO:
Nash Hospitals Systems, Inc.
2460 Curtis Ellis Drive
Rocky Mount, N.C. 27804
Attention: Patient Financial Services Review

NASH
UNC HEALTH CARE

FINANCIAL SCREENING APPLICATION

For Official Use Only

OTHER INSURANCE:	
Veterans Administration	Yes No
Medicare	Yes No
Medicaid	Yes No
Cobra	Yes No
Other	Yes No

Income Test	
Family Size	
Annual Income from worksheet (A)	$
Poverty Level from FPG worksheet	$
Below FPG	YES NO
Charity Adjustment % (per guidelines)	

Asset Test	
Value of Assets from worksheet (B)	$
Minus $10,000	$
Divide by 2	$
Countable Asset	$
Total of medical bills	$

Catastrophic Charity (if applicable)	
Annual Income	$
Catastrophic Discount	x 30%
Total Patient Owes	$
Total Medical Charges	$
Minus Patient Owes Amount	$
Charity Write-off Amount	$

APPROVED _____ DENIED _____

RECOMMENDATIONS:_____
_____
_____
_____

Reviewers Signature:_____ Date:_____

Director's Signature:_____ Date:_____