Wake Forest™
Baptist Health

Today's date: _____

Patient's name: _____

MRN: _____

Thank you for choosing Wake Forest Baptist Health (WFBH) for your health care needs. We have received your request to be evaluated for possible financial assistance with your medical bills. The items listed below are required in order to complete a review and determine your eligibility to qualify for assistance. Please return the information and/or documentation requested within 2 weeks from the date of service, date of discharge, or the date you applied for financial assistance. (*Please note: Additional information may be requested during the review process.)*

Items needed:

____ Copy of last year's 1099 forms, W2 forms, and/or tax returns.

____ Copy of household monthly income (check stubs, pay advices, unemployment printout, profit/loss statement for self-employment, SSI Benefit Letter, etc.)

____ Copy of your bank statements for the past two months (patient, spouse, both parents-if patient is a minor)

____ Copy of your government issued photo ID (NC Driver's License, NC Identification Card, Visa, Passport)

____ Proof of Exemption or Denial of insurance coverage through the Affordable Care Act. (If you were considered eligible for coverage, we will need proof that coverage was purchased)

____ Copy of your retirement account statement; ie. 401K, 403B, IRA, etc. (patient, spouse, both parents-if patient is a minor)

____ Other/Explain: Statement of Income/Housing, North Carolina Residency Declaration Form (enclosed)

Please feel free to call (336)716-3988 or 1-877-938-7497 if you have any questions. Our business hours are: Monday through Thursday: 8 am to 7pm, Friday: 8 am to 5 pm, and Saturday: 8:30 am to 1 pm.

Return all documentation to:

Patient Accounts and Collections
Attn: Patient Accounts
Medical Center Blvd
Winston Salem, NC 27157

*******CHARITY CARE ELIGIBILITY NOTICE*******

*If you have been financially screened by a Resource Recovery Specialist or Patient Account Representative at WFBH and have been told that you **MAY** be eligible for a Charity Care Discount, you must **FIRST** comply with the following requirements or you will be billed for the charges incurred:*

- *Apply for any State or Federal Programs as instructed and be found to be NOT ELIGIBLE.*
- *Provide any and all requested income documentation within 2 weeks from the date of service, or date of discharge, or the date you applied for financial assistance.*
- *Provide any and all requested signatures on application or any other Financial Assistance Forms.*

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STATEMENT OF INCOME/HOUSING

Patient _____ **Admit/Visit Date**_____

Account No.: _____ **MRN#:** _____

INCOME

_____ I have had no income for the past 12 months.

_____ My spouse had no income for the past 12 months.

_____ My spouse nor I had any income for the past 12 months.

_____ I had income in the amount of $_____for the past 12 months but cannot provide proof or verification.

_____ My spouse had income in the amount of $ _____for the past 12 months but cannot provide proof or verification.

HOUSING

_____ I am homeless and reside at: _____

_____ I am homeless with no specific residence

_____ I do not own or rent a residence. I live with friends or relatives.

I understand that falsification of any information provided will result in the revocation of any community benefits discount I may have qualified for or may have received.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Wake Forest Baptist Health
Patient Financial Statement

Addendum A

FOR INTERNAL USE ONLY

Today's Date: _____ Date Referred: _____

Referred By: _____ Ins: _____

CPI # and Visit #(s): _____ MRN #: _____

Admit/Discharge Date(s): _____

Diagnosis: _____

Procedure: _____

Est Charges: _____ Est Pt. Bal. _____ Est LOD: _____

Patient Name: _____ DOB: _____

Social Security Number: _____ County of Residence: _____

Mail Address: _____ City: _____ State: _____ Zip: _____

Phys. Address: _____ City: _____ State: _____ Zip: _____

Home # _____ Work # _____ Cell # _____

Emergency Contact Info: _____
(Name) (Relationship to Patient) (Phone #)

Person Providing Info: _____ Relationship to Patient: _____
(Name) (Self, Parent, Legal Guardian, etc.)

Is the patient a US Citizen? _____ If no, is the patient a legal Resident? _____

Patient Place of Birth: _____ Is the patient pursuing a citizenship? _____

Are you a Veteran? _____

Immediate Family Members Living in the Home: (Less than 18 years old or full time student)

Relationship: _____ Name: _____ DOB _____ SSN: _____

Relationship: _____ Name: _____ DOB _____ SSN: _____

Relationship: _____ Name: _____ DOB _____ SSN: _____

Relationship: _____ Name: _____ DOB _____ SSN: _____

Relationship: _____ Name: _____ DOB _____ SSN: _____

Relationship: _____ Name: _____ DOB _____ SSN: _____

Employment Information for Patient/Parent/Legal Guardian

Employer: _____ How Long At Current Employer: _____

Employee: _____ Relationship to Patient: _____

Hourly Wage: _____ Hours Worked per Week: _____

How Often Paid: _____ Monthly Gross Pay: _____

Date Last Worked: _____ Income while out of work: _____
(If currently unemployed)

Employer: _____ How Long At Current Employer: _____

Employee: _____ Relationship to Patient: _____

Hourly Wage: _____ Hours Worked per Week: _____

How Often Paid: _____ Monthly Gross Pay: _____

Date Last Worked: _____ Income while out of work: _____
(If currently unemployed)

Employment Information for Spouse

Employer: _____ How Long At Current Employer: _____

Employee: _____ Relationship to Patient: _____

Hourly Wage: _____ Hours Worked per Week: _____

How Often Paid: _____ Monthly Gross Pay: _____

Date Last Worked: _____ Income while out of work: _____
(If currently unemployed)

Employer: _____ How Long At Current Employer: _____

Employee: _____ Relationship to Patient: _____

Hourly Wage: _____ Hours Worked per Week: _____

How Often Paid: _____ Monthly Gross Pay: _____

Date Last Worked: _____ Income while out of work: _____
(If currently unemployed)

Social Security Retirement / Disability / Survivor Income / SSI / Veteran / Child Support / Work First Family / Unemployment

Current Accessible Trust Fund

Type: _____ Monthly Amt. _____ Received by: _____ Date Began _____

Type: _____ Monthly Amt. _____ Received by: _____ Date Began _____

Type: _____ Monthly Amt. _____ Received by: _____ Date Began _____

Type: _____ Monthly Amt. _____ Received by: _____ Date Began _____

Rental Income

None

_____ Per Month

Rental Property Address: _____

Other Income

Monthly amount:

Rcvd by: _____ Source(s): _____ Amt. _____

Rcvd by: _____ Source(s): _____ Amt. _____

Combined Gross Income for the Past Twelve Months: $ _____

(Use Adjusted Gross Income for Self Employed)

Comments:

_____

_____

Checking and Savings Accounts

None

Patient/Family Member Name: _____ Acct Type: _____ Acct Balance: _____

Financial Institution Name: _____ Location: _____

Patient/Family Member Name: _____ Acct Type: _____ Acct Balance: _____

Financial Institution Name: _____ Location: _____

Investments (CD, Money Market, IRA, 401K, Stocks, Annuities, Retirement Accounts, etc.):

None

Owner Name: _____ Type Investment: _____ Value: _____

Owner Name: _____ Type Investment: _____ Value: _____

Owner Name: _____ Type Investment: _____ Value: _____

Internal Use Only - Income Calculations

This section to be used to calculate Average Monthly or Weekly Income:
(transfer amount to "monthly" or "weekly gross pay" below)

Yearly income / YTD		# of Weeks / Months		Avg Monthly / Weekly Income	Source of Income:	Notes:
	÷		=	#DIV/0!		
	÷		=	#DIV/0!		
	÷		=	#DIV/0!		

Income Calculations for Past 12 months:

Hourly Rate $		Hours Worked		Monthly Gross Pay		Number of Months Worked		Yearly Income	Specific Details: (Date Range/Source of Inc/etc.)
	X		=	$0.00	X		=	$0.00	
	X		=	$0.00	X		=	$0.00	
	X		=	$0.00	X		=	$0.00	
	X		=	$0.00	X		=	$0.00	
					and / or				
				Weekly Gross Pay		**Number of Weeks**			
	X		=	$0.00	X		=	$0.00	
	X		=	$0.00	X		=	$0.00	
	X		=	$0.00	X		=	$0.00	
					and / or				
		Other (Specify):					=	$0.00	
		Other (Specify):					=	$0.00	

Grand Total of Yearly Income $ **$0.00**

Motor Vehicles/Motorcycles:

	None

Name on Title: _____ Tax Value _____ Balanced Owed: _____

Make/Model of Vehicle/Motorcycle: _____ Year: _____

Name on Title: _____ Tax Value _____ Balanced Owed: _____

Make/Model of Vehicle/Motorcycle: _____ Year: _____

Name on Title: _____ Tax Value _____ Balanced Owed: _____

Make/Model of Vehicle/Motorcycle: _____ Year: _____

Name on Title: _____ Tax Value _____ Balanced Owed: _____

Make/Model of Vehicle/Motorcycle: _____ Year: _____

Real Estate:

	None

Primary Residence: Own (Y/N) _____ Rent (Y/N) _____ Mortgage (Y/N) _____

State: _____ County: _____ Tax Value _____

Balance owed on the residence (Y/N): _____ Amount of Balanced Owed: _____

Other Real Estate: Own (Y/N) _____ Rent (Y/N) _____ Mortgage (Y/N) _____

State: _____ County: _____ Tax Value _____

Balance owed on the residence (Y/N): _____ Amount of Balanced Owed: _____

Other Personal Property: (Boats, campers, trailers, ATV's, tractors, etc.)

	None

Name on Title: _____ Est or Tax Value _____ Balanced Owed: _____

Description: _____

Name on Title: _____ Est or Tax Value _____ Balanced Owed: _____

Description: _____

By my signature below, I certify that the above information is an accurate and complete statement of my current financial position and give my permission to verify this information. WFBH reserves the right to reverse a discount previously recorded if it is determined that additional third party payer resources were available, or the information provided was false.

Signed By: _____ **Date:** _____

Relationship to Patient: _____