Wake Forest®
Baptist Health

Davie Medical Center

Financial Assistance Summary

Wake Forest Baptist Health recognizes the financial burden medical bills may cause for medically necessary services. Wake Forest Baptist Health provides financial assistance to patients who live within Wake Forest Baptist Health's service area. Determination of financial assistance is based upon a patient or legally responsible individual's household size, income and assets.

▶ Who qualifies for a discount?

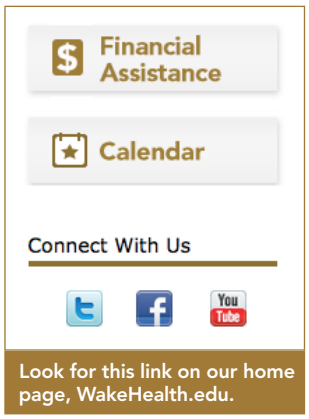
Any patient or other person who is legally responsible for a patient's medical bills, residing in the 19-county service area, regardless of age, gender and nationality.

▶ What services are covered?

Any hospital inpatient, outpatient or emergency care ordered and provided by a physician.

▶ How do I apply for financial assistance?

Financial Assistance information and an application can be found on our website at WakeHealth.edu, or can be obtained by contacting Customer Service at 336-713-4955, by visiting the Cashier's Office at any hospital campus (Winston-Salem, Lexington or Davie) or by visiting any of our registration areas within the clinic or admitting office. Financial Assistance applications are available in both English and Spanish.



▶ What information do I have to supply?

A financial application must be completed. In addition to the completed financial application, income documentation and proof of residency must be provided.

▶ How do I know if I am eligible for a discount?

Once your application is completed and income documentation and proof of residency are provided, a Wake Forest Baptist Health representative will process your information to determine a discount.

▶ Can someone help me apply for financial assistance and explain the financial assistance program?

Yes, assistance can be provided by contacting Customer Service at 336-713-4955, by visiting the Cashier's Office at any hospital campus (Winston-Salem, Lexington or Davie) or by speaking with a Financial Counselor at 336-716-0681.

Wake Forest® Baptist Health

Davie Medical Center

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 Information

Patient Name: _____ DOB: _____

Social Security Number: _____ County of Residence: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Physical Address: _____ City: _____ State: ____ Zip: _____

Home # _____ Work # _____ Cell # _____

Is the patient a U.S. citizen? _____ If no, is the patient a legal resident? _____

Immediate Family Members Living in the Home: (Younger than age 18 or a full-time student)

Relationship: _____ Name: _____ DOB _____ SSN: _____

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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)

continued on reverse

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)

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: _____

By my signature below, I certify that the above information is an accurate and complete statement of my current financial position, and I give my permission to verify this information. Wake Forest Baptist Health 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: _____