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.
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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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: ___________________________  (If currently unemployed)  Income While Out of Work: ___________________________
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: ________________ DateBegan: ________________

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: ________________________________