Our Community Hospital

Financial Assistance Application

Patient/Guarantor Information

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

Patient's Address: _____
Street *City* *State and Zip Code*

Patient's Date of birth: _____

Patient's Social Security Number: _____

Patient's Marital Status: _____
Single or Married

Note: If you are married, then you spouse's financial information and signature is required in order to process you application.

Spouse Information

Spouse's Name: _____
First *M.I.* *Last*

Spouse's Address: _____
Street *City* *State and Zip Code*

Spouse's Date of Birth _____

Spouse's Social Security Number: _____

Household Information

Number of Dependents: _____
Total Monthly Household Income (including social security income) _____

Household's value of assets beyond primary residence: _____
(Savings, Checking, Mutual Funds, Stocks, Rental, Alimony, etc.)

Our Community Hospital

Required Documentation

Attach copies for yourself and spouse as listed below:

- □ Most recent tax return, including W-2 forms and supporting schedules.
- □ Last 2 pay stubs
- □ Written verification of any other income received (e.g. child support, social security, alimony).

Or

- □ A letter from an employer verifying income (include employer's phone number and address).
- □ A letter or comment below from you stating your source for paying living expenses, if you have no income.

Additional Comments

Acknowledgement

I hereby acknowledge that the above information is true and accurate to the best of my knowledge.

I further grant the Health System authorization to verify any or all information given and also authorize a consumer credit report, if necessary.

Patient/Guarantor's Signature:_____Date:_____

Spouse's Signature:_____Date:_____

Mailing Instructions/Contact Information

Mail Documentation to:

Our Community Hospital
PO Box 405
Scotland Neck, NC 27874

Contact Information:

252-826-4144

Note: Please allow 4-6 weeks for processing