Sampson Regional Medical Center

Financial Assistance Request

	Patient / Guarantor # 1	Spouse / Guarantor # 2
A Family Information		
First Name, Middle Initial, Last Name		
Street Address		
City, State, Zip Code		
Social Security No. (XXX-XX-XXXX)		
Day Phone (XXX-XXX-XXXX)		
Evening Phone (XXX-XXX-XXXX)		
Employed (Yes / No / Self)	YES…….NO…….SELF……	YES…….NO…….SELF……
Name of Employer / Company		
Employer / Company Street Address		
City, State, Zip Code		
How long have you worked there?		
Number of Dependents		
B Financial Data (Monthly)		
Gross Salaries / Wages Before Taxes		
Business Income		
Rental Income		
Investment Income		
Income from Estates / Trusts		
Alimony Income		
Child Support		
Social Security Benefits		
Aid to Dependent Children		
Public Assistance Income		
Other Income (List Below)		
Total Income from All Sources		
C Financial Data (Assets)		
Cash on Hand		
Checking Account(s) - Current Balance		
Savings Account(s) - Current Balance		
Mutual Funds - Current Value		
Stocks - Current Value		
Bond(s) - Current Value		
Home - Assessed Value		
Rental Property - Assessed Value		
Business Property - Assessed Value		
Automobile(s) - Estimated Value		
List Year / Make / Model		
Recreational Vehicle(s) - Estimated Value		
Boat(s) - Estimated Value		
Total Assets		
Signature(s)		

SAMPSON REGIONAL MEDICAL CENTER
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Comments / Reason for Request:

_____
_____
_____
_____
_____
_____
_____
_____

Requirements:

- Must be a Sampson county resident
- Must not have declined Health Insurance
- Must not be on Medicare or Medicare HMO Plan

The following information must be attached to the Financial Assistance Request:

- Copy of your most recent tax return, including W-2 earnings form(s);
- Copy of last 2 pay stubs;
- Written verification of any other income received, including child support, Social Security, alimony, unemployment, assistance from relatives / friends, etc. If none, please state this on the comments line above.
- Copy of Medicaid denial letter from the Department of Social Services.

Mail all documents to:

Sampson Regional Medical Center
P O Box 258
Attention: Business Office
Clinton, NC 28328

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 #1-signature Date

Patient/guarantor #2-signature Date