SAMPSON
REGIONAL MEDICAL CENTER
607 Beaman Street, Clinton, NC
910.592.8511
www.SampsonRMC.org

FINANCIAL ASSISTANCE APPLICATION CHECKLIST

DATE:_____ ACCOUNT #_____

NAME:_____

To apply for financial assistance on your bill(s) you must meet the following requirements

___ 1. Must be a resident of Sampson County or:
  ____ a) Out of county resident who arrived at SampsonRMC's ER by ambulance/rescue.
  ____ b) Out of county resident who was referred to SampsonRMC for inpatient or outpatient services by an active member of the SampsonRMC medical staff.
___ 2. Must not be eligible for Medicare or Medicaid.
___ 3. Must not have declined health insurance offered by employer, spouse's employer, guardians employer.
___ 4. Services must not be related to any liability case. (Auto accident, or other third party liability)

In order to determine if you qualify for financial assistance, we need the documents checked below returned with these forms to the business office which is located on Beaman Street directly across from the front of the hospital. (Sampson Regional Financial Services). They can also be mailed to PO Box 260 Clinton, NC 28329. If you have any questions or need further assistance please call the Financial Services office at 910-590-8753.

CHECK LIST:

____Need written verification that you are not eligible for Medicaid. This is not required if you have health insurance. If Medicaid is pending, return your application with all other required information and documents to meet the 30 day timeframe.
____Copy of your most recent tax return with all W-2 Forms and/or 1099 and 1040 Forms.
____Copy of your 2 most recent pay stubs or proof of income.
____Written verification of any other income received (child support, Social Security, alimony, unemployment, aid to dependent children, food stamps, disability income, and assistance from relative/friend, etc)
____If unemployed indicate in the comment section of the hardship form the date you last worked and how your current living expenses are being paid.

Comments/Reason for request:_____

_____

I hereby acknowledge that the information contained is true and accurate to the best of my knowledge. I further grant SampsonRMC authorization to verify any or all information give, and also authorize a consumer credit report if necessary.

Patient/guarantor #1 –signature _____

Spouse/guarantor #2 –signature_____

If required information is not returned within <u>30 days</u> from the date at the top of this form, the request for financial assistance will be <u>denied</u>.

SAMPSON
REGIONAL MEDICAL CENTER
607 Beaman Street, Clinton, NC
910.592.8511
www.SampsonRMC.org

FINANCIAL ASSISTANCE REQUEST

A. Family Information	**Patient/Guarantor #1**	**Spouse/Guarantor #2**
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)		
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		
Total Assets		
Signatures		