erlanger
Western Carolina Hospital

ERLANGER WESTERN CAROLINA HOSPITAL FINANCIAL ASSISTANCE APPLICATION

The intent of the Erlanger charity policy is to establish a fair and equitable system for determining hospital charity. General guidelines are established, allowing for evaluation of unique financial circumstances. In order for you or your family member to be considered under our financial assistance program, the below financial information must be provided.

1. Latest 2 months bank statements.
2. Tax Return or 2 most recent pay stubs.

The application must be returned to Erlanger Western Carolina Hospital at the below listed address.

Erlanger Western Carolina Hospital
Patient Financial Services
3990 E. US Hwy 64 Alt
Murphy, NC 28906

A stamped self-addressed envelope has been provided to return the financial information.
If you have any questions in regards to this application, please contact our Financial Counseling Department at (828) 835-3662.

Sincerely,

Financial Counselor

The financial information listed above must be provided within 30 days of application. If the above documentation is not provided, your charity care application may be denied.

ERLANGER WESTERN CAROLINA HOSPITAL FINANCIAL ASSISTANCE APPLICATION

Erlanger Western Carolina Hospital * 3990 E. US Hwy 64 Alt * Murphy, NC * 28906

PATIENT NAME: _____

PATIENT ACCOUNT # _____ **MEDICAL RECORD #** _____

RESPONSIBLE PARTY			
NAME OF HEAD OF HOUSEHOLD	MARITAL STATUS	SOCIAL SECURITY#	DATE OF BIRTH
STREET ADDRESS, CITY, STATE, ZIP	HOW LONG AT THIS ADDRESS	HOME PHONE	
EMPLOYER NAME AND ADDRESS	BUSINESS PHONE	LENGTH OF EMPLOYMENT	
HEALTH INSURANCE NAME	POLICY HOLDER	EFFECTIVE DATES	
SPOUSE			
NAME		SOCIAL SECURITY#	
EMPLOYER NAME AND ADDRESS	BUSINESS PHONE	LENGTH OF EMPLOYMENT	

HOUSEHOLD INFORMATION (DEPENDENTS UNDER AGE 18)		
NAME	**DOB**	**RELATIONSHIP**
Total persons in household:		

ERLANGER WESTERN CAROLINA HOSPITAL FINANCIAL ASSISTANCE APPLICATION

Erlanger Western Carolina Hospital * 3990 E. US Hwy 64 Alt * Murphy, NC * 28906

INCOME		
ESTIMATED MONTHLY INCOME (*TO INCLUDE ALIMONY, CHILD SUPPORT,DISABILITY) $*		
ESTIMATED MONTHLY LIVING EXPENSES $		
AMOUNT RECEIVE FOR FOOD NUTRITION SERVICES $:		
Do you currently have a lawsuit pending or have or are considering a claim that could lead to you receiving additional monies?		
ASSETS		
CHECKING $	SAVINGS $	CD'S $
IRA $	INVESTMENTS $	OTHER $
TOTAL ASSETS:		

VEHICLES/RECREATIONS *(BOAT/TRAILER/MOTOR HOME)*				
MAKE	**MODEL**	**YEAR**	**MONTHLY PMT**	**VALUE**

Incomplete or fraudulent applications will be denied. Fraudulent information may also lead to revocation of charity assistance if discovered after it has been granted.

In completing this financial assistance application, I hereby affirm that the above statements are correct and complete. I give my consent to further verification by Erlanger hospital or its agents.

SIGNATURE: _____

APPLICATION DATE: _____

RELATIONSHIP IF OTHER THAN PATIENT: _____

****DOCUMENTATION MUST BE SUPPLIED IN ACCORDANCE WITH THE ENCLOSED OR ATTACHED LETTER AND THE FINANCIAL ASSISTANCE POLICY.***