

FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS

Erlanger has a financial assistance policy (FAP) that provides for free or discounted care (financial assistance) to those who qualify. You should review the full policy for further information.

All persons, whether insured or uninsured, may apply for financial assistance. On the following page, please find the application form. **Please note that FA is determined by looking at Family Income (before taxes and deductions)**. Please see the policy for a definition of Family Income, but, generally, all persons who are related by blood or marriage and who reside together are considered Family. In addition to the filling out the attached form, you must provide all of the following documentation for your application to be complete:

- The most recent tax returns for all Family members. This includes tax returns for both spouses who do not file jointly and tax returns for any related person who is required to file a tax return and who resides in the same household. If any member of the family is self-employed or the owner of a business, they must also provide Schedule C, Schedule F, and Schedule K-1 as applicable. A Family member may also submit a recent pay-stub instead of a tax return if they have no other source of income other than the job reflected on the paystub.

AND

- Most recent statements for any and all bank, checking, savings, investment or other depository accounts in which a Family member has an ownership interest or withdrawal, signing or check writing authority.

AND

- A list of any potential claims or pending lawsuit that may result in the recovery of money or property for a patient or Family member.

Although not required, you may also include a letter with your application that describes any particular hardship or other information you think is relevant to the financial assistance determination.

If you do not have all of the required documentation and want to discuss acceptable alternatives, have questions about FA or would like assistance in applying please contact PFS. After you complete the attached form, please mail it with all required documents to:

Patient Financial Services (PFS)
3990 E. US Hwy. 64 Alt.
Murphy, NC 28906
828-835-3662/ 828-837-3897

Please note that Erlanger or its agents will verify any information provided. Any misleading, incomplete or fraudulent applications will be denied. Providing fraudulent, significantly inaccurate, or incomplete information may result in the revocation of financial assistance if such inaccuracies are discovered after financial assistance has been approved.

Additionally, any information you provide may be used to seek payment for medical bills, including, but not limited to, screening for other insurance or programs.

ERLANGER HEALTH SYSTEM FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____

Patient No.: _____ Medical Record No.: _____

Provide additional pages with information if more space is required to answer any of the following:

RESPONSIBLE PARTY			
Name	Marital Status	Social Security Number	
Address	How long at this Address?	Home Phone No.	
Employer Name and Address	Business Phone No.	Position/Title & Length of Employ.	
SPOUSE			
Name			Social Security Number
Employer Name and Address	Business Phone No.	Position/Title & Length of Employ.	
HOUSEHOLD INFORMATION (All Persons in Household)			
Name	DOB	Relationship	Employer and Gross Monthly Income (including SS, Disability, Child Support, Alimony, Wages, Dividends, Rents, Profits, Draws, Distributions)
Total Persons in Household:		Total Household Monthly Income Before Taxes:	
Estimated Household Monthly Living Expenses:			
Do you or anyone in the household have any potential claims or pending lawsuits that might result in the recovery of money or property for you or a household member? If so describe:			
HOUSEHOLD ASSETS (value)			
Checking & Savings: \$	Investments: \$	CDs: \$	
IRA/401(k): \$	Other: \$	Business Ownership: \$	
Do you or any Household member own any real estate? If so, list the owner(s), address(es), value(s) and any amount owed on a mortgage.			
Is any Household member the beneficiary of a trust? If so, identify the trust, the trustee and contact information, and describe any distributions.			
HOUSEHOLD MOTOR AND RECREATIONAL VEHICLES (Cars, Trucks, RVs, Boats, Motorcycles, etc.)			
Year, Make, Model and Owner	Monthly Payment	Current Value	Current Amount Owed

I hereby affirm and attest that my application (including required documents) is true, complete and correct. I consent for Erlanger or its agents to verify any information I provide using third-party sources and to use such information in seeking payment for medical bills, including, but not limited to, screening for other insurance or programs.

Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Relationship if other than the Patient: _____

*****Attach Required Documentation as described in the Instructions for a complete application*****