CAROLINAEAST MEDICAL CENTER
FINANCIAL ASSISTANCE APPLICATION

Please provide proof of income for all family members (guarantor, patient, dependents) living in the patient's home such as the most recent Tax Return, Social Security Statement, Pension/ Retirement Statement. We will make copies for you. If you didn't file a tax return and had income, please let us know. Accounts within three years of the discharge date may qualify for financial assistance**.**

Date ____/____/____

Patient Name _____ Acct. Number(s) _____

Guarantor's Name _____ Relationship to Patient _____

Phone _____

Social Security # _____

Employers: Patient/ Guarantor _____

Spouse _____

Number of Family members (dependents of patient or guarantor) living in the household

Family Members' Names	Relationship to Guarantor	Age	Monthly Income
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

Assets

Please provide recent Bank Statements

Savings	$ _____	
Checking	_____	
Building or Second Home	_____	
Value of Home	_____	
Stocks & Bond Securities	_____	
IRA, Pension, Annuities	_____	(current value)
Cash on Hand	_____	
Other Assets	_____	
Total Assets	$ _____	

Gross (before taxes) Monthly Income

Patient's Income	$ _____
Spouse's Income	_____
Dependents	_____
Social Security Income	_____
Veteran's Benefit	_____
Interest Income	_____
Other Income	_____

Food Stamps _____

Total Gross Monthly Income $ _____

Expenses for Necessities

Rent or Mortgage (Including Real Estate Taxes-circle one)			$ _____
Value of Home			$ _____
Mortgage Balance			$ _____
Car Payment	_____	RX	_____
Make/Model/Year of Car	_____	Estimated value	_____
Electric	_____	Water/Sewer	_____
Loans	_____	Credit Cards	_____
Household gas	_____	Cable	_____
Telephone	_____		_____
Average Food Payments			_____
Child Care Fees			_____
School Tuition			_____
Medical Bills			_____
Health Insurance			_____
Other			_____
Total Monthly Expenses			$ _____

Net Monthly Disposable Income $ _____

Monthly Amount to be Paid from Disposable Income, if applicable $ _____

The undersigned certifies that the above statements are true and have been made for the purpose of making application for Financial Assistance. CarolinaEast Medical Center is authorized to obtain relevant information deemed necessary to process this application including obtaining a consumer credit report. I acknowledge that my application may be denied if I fail to provide required financial documentation.

Date of Request Applicant's Signature

____/____/_____ _____

Income Requirements:

Charity - To qualify the household gross income from all sources must not exceed (200%) of the Federal Poverty guideline.
Amount Generally Billed (AGB) Discount - To qualify the household gross income must be between (201%) and (250%) of the Federal Poverty guideline.
Other restriction may apply, i.e. excessive assets.

Payment plans are available

For More Information:

Please call or email the Medical Center's Business Office with questions.
(252) 633-8701, businessoffice@carolinaeasthealth.com.