SAMPSON
REGIONAL MEDICAL CENTER

612 Beaman Street, Clinton, NC
910.590.8751
www.SampsonRMC.org/FinancialAssistance

Return completed application and any required additional information to: Sampson Regional Medical Center's Business Office, located at 612 Beaman Street, Clinton, NC or mail to PO Box 260, Clinton, NC 28329

Financial Assistance Application

Please fill out all information completely. If it does not apply, write "NA". Attach additional pages if needed.

Screening Information

Do you need an interpreter? ☐ Yes ☐ No If Yes, list preferred language:_____
Has the patient applied for Medicaid? ☐ Yes ☐ No (May be required to apply before being considered for financial assistance.)
Does the patient receive state public services such as TANF or SNAP Benefits? ☐ Yes ☐ No
Is the patient's medical care need related to a car accident or work injury? ☐ Yes ☐ No
Does the patient's employer/spouse's employer/guardian's employer offer health insurance? ☐ Yes ☐ No
(If no, must have letter from employer.)

Do you file a federal tax return? ☐ Yes ☐ No If no, list why:_____

Please Note

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

Patient and Applicant Information

Patient First Name:_____ Middle Name:_____ Last Name:_____
Birthdate:_____

Person Responsible for Paying Bill:_____ Relationship to Patient:_____
Birthdate:_____

Mailing Address:_____ City:_____ County:_____
State:_____ Zip:_____
Main Contact Phone Number(s):_____ _____
Email Address:_____
Employment status of person responsible for paying bill: ☐ Employed (date of hire:_____)
☐ Unemployed ☐ Self-Employed ☐ Student ☐ Disabled ☐ Retired ☐ Other:_____

Family Information

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income:	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:
Wages, Unemployment, Self-employment, Worker's Compensation, Disability, SSI, Child/Spousal Support, Work Study Programs (students), Pension, Retirement Account Distributions, Alimony Income, Rental Income, Investment Income,
Other (please explain)_____

Income Information

REMEMBER: You must include proof of income with your application and return to Sampson Regional's Business Office located at 612 Beaman St Clinton, NC or mailed to PO Box 260 Clinton, NC 28329.

You must provide information on your family's income. Income verification is required to determine financial assistance.

Examples of proof of income include:

- A "W-2" withholding statement or 1099 or 1040
- If self employed, gross business income - Schedule C
- Last year's income tax return, including schedules if applicable.
- Copy of pay stubs or proof of income covering 30 days.
- 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.)
- 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.
- If unemployed, explain in the comment section below how you currently pay your bills.

Comment:_____

_____

If you have no proof of income or no income, please attach an additional page with an explanation.

Expense Information

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/Mortgage $_____ Medical Expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (child support, loans, medications, other)

Asset Information

This information may be used if your income is above 101% of the Federal Poverty Guidelines.

Current Checking Account Balance $_____ Bank Name:_____

Current Saving Account Balance $_____ Bank Name:_____

Cash on Hand $_____

Home Assessed Value $_____

Second Home Assessed Value $_____

Auto Estimated Value $_____

Auto Estimated Value $_____

Auto Estimated Value $_____

Does your family have these other assets? Please check all that apply.

☐ Stocks ☐ Bonds ☐ 401K ☐ Health Savings Account(s) ☐ Trust(s) ☐ Property (excluding primary residence)

☐ Own a Business

Additional Information

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

Patient Agreement

I understand that Sampson Regional Medical Center and its practices may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date