Atrium Health

Financial Assistance Application

Financial assistance is a program for patients who receive services at Atrium Health. Eligibility is based on family size and household income as compared to federal poverty guidelines.

Please fill out all information completely to prevent any delays in processing your application.

Patient Information

Patient Name	Social Security#	Date of Birth	Account#

Applicant Information

Applicant Name	Relationship to Patient	Social Security#	Date of Birth	Marital Status

Address	City, State and Zip Code

Home Phone#	Cell Phone#	Emergency Contact Name	Emergency Contact Phone#

Employer Name	Employer Address	Work Phone

NOTE: If the address where you receive mail is different from the address where you live, please fill out the 'mailing address' information below

Mailing Address	City, State and Zip Code

Health Insurance Information

☐ Check this box if the patient does not have any source of health insurance coverage

Health Insurance Provider	Policy Holder Name	Policy#	Group#	Effective Date

Has a member of the household lost their job within the past 60 days?	☐ Yes ☐ No
Did he/she receive a COBRA election notice?	☐ Yes ☐ No
Did he/she elect COBRA coverage?	☐ Yes ☐ No
If he/she did not elect COBRA coverage, please check one: ☐ COBRA premiums too expensive ☐ has new coverage	

Please list all household members below

	Name	Social Security#	Date of Birth	Relationship to Patient
1				
2				
3				
4				
5				
6				
7				
8				

NOTE: please list any additional members of the household in the 'notes' section on page 3 of this form

Monthly Household Income

Type of Income	Monthly Gross Income for Applicant	Monthly Gross Income for Applicant's Spouse
Employment Income	$	$
Retirement/Pension/Social Security Retirement	$	$
Social Security Disability Income	$	$
Unemployment Income	$	$
Child Support/Alimony	$	$
Other (list source here _____)	$	$

Statement of Support

I certify that I have been unemployed for the last _____ years / _____ months. As a result of being unemployed, I receive food, shelter and clothes from _____ (relationship to applicant = _____)

Acknowledgement and Signatures

I hereby certify that the information provided in this application is true, accurate and complete to the best of my knowledge. I hereby authorize the Hospital to contact any person, firm or organization to verify any of the information given and I hereby authorize any such person, firm or organization to release to the Hospital any financial information it may request.

Applicant Signature Date

Mail Completed Application to:

Atrium Health System Business Office

Attention: Financial Assistance Services

PO Box 32861

Charlotte, NC 28232

Notes