



### Hardship Overview

The information requested in this application is required to determine eligibility for a Hardship Discount. The Hardship Discount program is for insured or uninsured patients who are over the income limit for Financial Assistance. Eligibility is based on balances due for services received at Atrium Health in comparison to the patient's household income.

### Requirements to Apply for the Hardship Discount

To be considered for the Hardship Discount, the patient must meet the following requirements:

- Resident of North Carolina, South Carolina, Georgia or Alabama
- The patient must fully cooperate with the Hardship review process. If additional information and/or proof documents are needed to complete the application, a letter will be mailed to the patient to let them know what is needed and the deadline to submit. If the information requested is not received by the deadline, the patient will not be eligible.

### What to Expect: The Eligibility Review Process

Eligibility will be determined in a timely manner from the date the application is received by the Coverage Assistance Services Team at Atrium Health. Once the eligibility review is complete, a letter will be mailed to the patient to let them know if they have been approved or denied.

Please complete all 3 pages of this form. Filling out this form completely will help to prevent delays in the review process.

Patient Information			
Patient Name	Social Security#	Date of Birth	Account#

Applicant Information				
Applicant Name		Relationship to Patient	Social Security#	Date of Birth
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
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## 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?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did he/she receive a COBRA election notice?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did he/she elect COBRA coverage?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
If he/she did not elect COBRA coverage, please check one:		<input type="checkbox"/> COBRA premiums too expensive <input type="checkbox"/> has new coverage		

Please list all household members below

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

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 Business Office  
Attention: Coverage Assistance Services  
PO Box 32861  
Charlotte, NC 28232

## Notes