# Hardship Settlement Discount Application

## Hardship Settlement Overview

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

## Requirements to Apply for the Hardship Settlement Discount

To be considered for the Hardship Settlement 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 Settlement 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 the patient to let them know if they have been approved or denied.

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Please complete all **4** 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 | Marital Status |
| Address | | | City, State and Zip Code | | |
| Home Phone# | Mobile 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 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 | | | | |

**NOTE:** please list any additional members of the household in the 'notes' section on page 4 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 _____) | $ | $ |

## Financial Assets

| Source | Name of Bank or Financial Institution | Applicant | Applicant's Spouse |
|---|---|---|---|
| Checking Account | | $ | $ |
| Savings Account | | $ | $ |
| Money Market | | $ | $ |
| Certificate of Deposit | | $ | $ |
| Stocks/Bonds | | $ | $ |
| Mutual Funds | | $ | $ |
| Trust | | $ | $ |
| Pre-Paid Debit | | $ | $ |
| Promissory Note | | $ | $ |
| Other (_____) | | $ | $ |

## Property please list **all** properties owned below

| Address | Tax Value | Loan Balance | Name of Mortgage Lender |
|---|---|---|---|
| | $ | $ | |
| | $ | $ | |
| | $ | $ | |

## 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: Coverage Assistance Services
PO Box 32861
Charlotte, NC 28232

## Notes