Wake Forest® Baptist Health

Addendum A

Patient Financial Assistance Application

FOR INTERNAL USE ONLY

Application Taken By: ______________________________

Today's Date: ______________________________ Date Referred: ______________

Referred By: ______________ Reason for Referral: ______________________________

Ins: ______________ Guarantor #(s): ______________ MRN #: ______________

Admit/Discharge Date(s): ______________________________

Diagnosis: ______________________________

Procedure: ______________________________

Est. Charges: ______________ Est. Pt. Bal.: ______________ Met 12/mo LOD Criteria?: ______________

If yes, why?: ______________________________

Patient Information:

Patient Name: ______________________________ DOB: ______________

Social Security Number: ______________ County of Residence: ______________ Marital Status: ______________

Mailing Address: ______________________________ City: ______________ State: ____ Zip: _______

Physical Address: ______________________________ City: ______________ State: ____ Zip: _______

Home #: ______________ Work #: ______________ Cell #: ______________ Email Address: ______________

Is the patient a U.S. citizen? ______________ If no, is the patient a legal resident? ______________ Length as legal resident? : ______________

Visa type: ______________ Is the patient pregnant?: ______________

Immediate Family Members Living in the Home (Include spouse and children younger than 18)

Relationship: __________ Name: ______________ DOB: ______________ SSN: ______________ Medicaid Recipient?: ______________

Relationship: __________ Name: ______________ DOB: ______________ SSN: ______________ Medicaid Recipient?: ______________

Relationship: __________ Name: ______________ DOB: ______________ SSN: ______________ Medicaid Recipient?: ______________

Relationship: __________ Name: ______________ DOB: ______________ SSN: ______________ Medicaid Recipient?: ______________

Relationship: __________ Name: ______________ DOB: ______________ SSN: ______________ Medicaid Recipient?: ______________

Relationship: __________ Name: ______________ DOB: ______________ SSN: ______________ Medicaid Recipient?: ______________

Employment Information for Patient/Parent/Legal Guardian/Spouse

Currently Employed?: _____ Employer: ______________________________ How Long at Current Employer: ______________

Employee: ______________________________ Relationship to Patient: ______________________________

Date Last Worked: ______________ Hourly Wage: ______________ Hours Worked per Week: ______________

How Often Paid: ______________________________ Monthly Gross Pay: ______________________________

Date Last Worked: ______________________________ Income While Out of Work: ______________________________

Employment Information for Patient/Parent/Legal Guardian/ Spouse

Currently Employed?: _____ Employer: ______________________________ How Long at Current Employer: ______________

Employee: ______________________________ Relationship to Patient: ______________________________

Date Last Worked: ______________ Hourly Wage: ______________ Hours Worked per Week: ______________

How Often Paid: ______________________________ Monthly Gross Pay: ______________________________

Date Last Worked: ______________________________ Income While Out of Work: ______________________________

Additional Income (Alimony, Current Accessible Trust Fund, Child Support, Disability, Interests and Dividends, Public Assistance, Real Estate, Rentals and Leases, Retirement, Settlement Income, Social Security, SSI, Survivor Income, Unemployment, Veteran's Benefit, Work First Family, etc):

Type: ______________ Monthly Amt.: ______________ Received by: ______________ Date Began: ______________

Type: ______________ Monthly Amt.: ______________ Received by: ______________ Date Began: ______________

Type: ______________ Monthly Amt.: ______________ Received by: ______________ Date Began: ______________

Does anyone in the home have any of the following resources or assets?

Liquid Assests	Mark, if yes	Owner	Bank	Amount
Cash				
Checking account				
Savings account				
Money Market account				
401K/IRA				
Life Insurance (Term/Whole)		Face Value	Cash Value	
Stocks, CDs, Bonds				
Other				

Personal Property	Mark, if yes	Owner	Type	Value
Vehicle				
Vehicle				
Vehicle				
Mobile Home				
Motorcycle				
Primary Residence (House/Land)				
Additional Real Estate				
Rental Property				
Boats/Campers/Trailers				
Other				

By my signature below, I certify that the above information is an accurate and complete statement of my current financial position, and I give my permission to verify this information. I understand I may be asked to provide documentation of the information stated in this application. Wake Forest Baptist Health reserves the right to reverse a discount previously recorded if it is determined that additional third-party payer resources were available or the information provided was false.

Signed by: ______________________________ **Date:** _________________

Relationship to Patient:_______________________________________