

BEAUFORT REGIONAL HEALTH SYSTEM

Financial Assistance Application

Return Completed form & supporting documents to: Beaufort Regional Health System

Patient Financial Services Department

628 East 12th Street

Washington, NC 27889

Ph # (252-) 975-4228

Account Number		Medical Record	
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Guarantor Information	Patient Information	Spouse Information
Name:	Name:	Name:
SS#:	SS#:	SS#:
DOB:	DOB:	DOB:

Guarantor Address	How long at this address?
	What county do you live in?

Patient Address	How long at this address?
	What county do you live in?

In what state do you file your taxes?		US Citizen?	__ Yes	__ No
Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Separated	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced

Health Insurance/ Other Assistance					
Are you covered by any of the following? (Check all that apply)					
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Health Ins	<input type="checkbox"/> Cancer Program	<input type="checkbox"/> Blind Comm	<input type="checkbox"/> Other
<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Cripple Children	<input type="checkbox"/> Voc Rehab	<input type="checkbox"/> Migrant Hlth	<input type="checkbox"/> Veteran's Admin	

Have you applied for Medicaid?		If yes, when:		What County?		
Caseworker's Name:				Food Stamps	__Yes	__No

Employment History (Attach additional documentation if necessary)					
Patient or Guarantor's employer:				From:	To:
Salary	Hr/Wk/Mo/Yr	Average # of hrs worked per week:		Phone #:	
Prior Employer's Name:				From:	To:
Salary	Hr/Wk/Mo/Yr	Average # of hrs worked per week:		Phone #:	
Spouse's Employer:				From:	To:
Salary	Hr/Wk/Mo/Yr	Average # of hrs worked per week:		Phone #:	
Prior Employer's Name:				From:	To:
Salary	Hr/Wk/Mo/Yr	Average # of hrs worked per week:		Phone #:	

All Other Income for Patient, Guarantor or Spouse (Check all that apply) Attach Proof of Income

<input type="checkbox"/> Unemployment	\$	<input type="checkbox"/> SSI	\$	<input type="checkbox"/> VA	\$
<input type="checkbox"/> Worker's Comp	\$	<input type="checkbox"/> Child Support	\$	<input type="checkbox"/> Investments	\$
<input type="checkbox"/> Alimony	\$	<input type="checkbox"/> Pension	\$	<input type="checkbox"/> Retirement	\$
<input type="checkbox"/> Social Security	\$	<input type="checkbox"/> Disability	\$	<input type="checkbox"/> Other	\$

If no income, please explain

Family Members

Please list the names and ages below

Name		Age	Name		Age
Name		Age	Name		Age

Assets (attach additional pages if necessary)

Primary Residence	\$
Other Real Estate	\$
Bank Accounts	\$
Retirement Accounts	\$
Stocks	\$
Mutual Funds	\$
Trust Accounts	\$
Other	\$
Cash Value of Life Ins	\$
Total Assets	\$

Liabilities	Current Bal	Mo Payment
Mortgage Balance	\$	\$
Mortgage Balance	\$	\$
Bank Credit Cards	\$	\$
Other Cards	\$	\$
Utilities	\$	\$
Rent	\$	\$
Other Vehicles	\$	\$
Other	\$	\$
Loans against Life Ins	\$	\$
Total Debt	\$	\$

Types of Vehicles

Make		Model		Year	
Make		Model		Year	
Make		Model		Year	

Banking Information

Name of Bank		Location	
Account Number(s)			
Name of Bank		Location	
Account Number(s)			

Life Insurance Policies

Name of Company	Face Value	
Name of Company	Face Value	
Name of Company	Face Value	

Certification

I certify that the above information is correct to the best of my knowledge. I authorize the release of any of this information from my employer and or holders of this information, for the purpose of evaluating assistance in the payment of my medical bills and verification of my income, expenses and assets. **I give Beaufort Regional Health System permission to verify my financial information to include credit reports and public records.**

Patient /Guarantor signature	Date	
Interviewer's Signature	Date	

