CHESAPEAKE REGIONAL HEALTHCARE

Chesapeake Regional Healthcare Financial Assistance Application

Applicants must submit all required documents in the same mailing or fax to:
Fax #: (757) 312-6591 Mailing Address: ATTN: Financial Counselor 736 Battlefield Boulevard, North Chesapeake, VA 23320.

Patient Name:	**Date of Birth:**	**Account #**
Address:	**Social Security #:**	**Phone #:**
Marital Status:	**Employer:**	**Spouses employer:**

Unemployment Verification: ***I attest that I have been unemployed since _____ and my last employer was_____.***

FAMILY MEMBERS: *List spouse or dependents as listed on tax return.*

Name	**Age**	**Relationship**

PLEASE CHECK IF YOU RECEIVE OR CURRENTLY HAVE THE FOLLOWING RESOURCES:

☐SNAP ☐FOOD STAMPS ☐GOVERNMENT INCOME HOUSING ☐GAP MEDICAID ☐PLAN FIRST

Please answer the following questions below and provide the required documents:

Please answer all questions listed below	If **YES**, please provide the following documents for **EACH** member of the household
Do you have health insurance? ☐ Y ☐ N **If no**, Have you attempted to apply for Medicaid in the last 6 months and been denied? ☐ Y ☐ N (Please provide validation letter)	**UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY VENDOR PRIOR TO RECEIVING ASSISTANCE.**
Is any member of your household **employed**? ☐ Y ☐ N	3 current pay stubs **or** tax return from the most recent tax year.
Is any member of your household **self-employed**? ☐ Y ☐ N	Complete tax return packet from the most recent tax year.
Is any member of your household receiving **unemployment benefits**? ☐ Y ☐ N	Benefit letter or Unemployment printout from State website.
Is any member of your household receiving **social security**? ☐ Y ☐ N	Social Security benefit letter
Does any member of your household have a **Retirement or Pension** (401K, IRA, 403b) ☐ Y ☐ N	Pension/Retirement benefit letter or statement of current balance.
Does any member of your household receive **child support**? ☐ Y ☐ N	Court order document.
Does any member of your household have a **checking, savings, or money market account?** ☐ Y ☐ N	Attach complete copy of current 30 day statement for each account.
Does any member of your household have **any other source of income?** ☐ Y ☐ N	GI bill, dividend, rental property, etc.… Attach current statement(s)

I certify the above information is correct and true. I authorize Chesapeake Regional Healthcare to verify this information with employers and other agencies. I understand this information is subject to review by federal and/or state agencies. I understand I must provide required documents in order to complete this application. Incomplete applications will be denied. ***PLEASE NOTE APPLICATION WILL NOT BE CONSIDERED ON ACCOUNTS THAT ARE WITH A COLLECTION AGENCY. *

Signature: _____ **Date:** _____

It is the patient's responsibility to confirm we received your application and documents. (757)312-6281