

FINANCIAL ASSISTANCE APPLICATION

Applicants must submit all required documents in black or blue ink and submit in the same mailing envelope or fax to **757-312-6591** or mail to **Chesapeake Regional Healthcare, Attn: Financial Counselor, 736 Battlefield Blvd., North, Chesapeake, VA 23320.**

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

Check the box if the patient is a minor

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 AND PROVIDE CURRENT VALIDATION:

- WIC
 SNAP
 FOOD STAMPS
 SUBSIDIZED/LOW INCOME HOUSING
 HOMELESS
 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Have you attempted to apply for Medicaid in the last 6 months and been denied? (Please provide validation letter.) <input type="checkbox"/> Yes <input type="checkbox"/> No	UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY VENDOR PRIOR TO RECEIVING ASSISTANCE.
Is any member of your household employed ? <input type="checkbox"/> Yes <input type="checkbox"/> No	3 current pay stubs or tax return from the most recent tax year
Is any member of your household self-employed ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Complete tax return packet from the most recent tax year
Is any member of your household receiving unemployment benefits ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Benefit letter or Unemployment printout from State website
Is any member of your household receiving social security ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security benefit letter
Is any member of your household covered by Medicare ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide CRH Medicare expense sheet
Does any member of your household receive alimony or child support ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Court order document
Does any member of your household have a checking, savings, or money market account ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Attach complete copy of current 30-day statement for each account
Does any member of your household have any other source of income ? <input type="checkbox"/> Yes <input type="checkbox"/> No	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 and acknowledge 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. Please call 757-312-6281.